MEDICARE PRESCRIPTION DRUG BENEFITS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SECOND CONGRESS

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MEDICARE PRESCRIPTION DRUG BENEFITS

TUESDAY, JUNE 11, 1991

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to call, at 10:30 a.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
FRIDAY, MAY 31, 1991

PRESS RELEASE #12
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
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THE HONORABLE FORTNEY PETE STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON MEDICARE PRESCRIPTION DRUG BENEFITS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on providing prescription drug benefits under Medicare. The hearing will be held on Tuesday, June 11, 1991, beginning at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building.

In announcing the hearing, Chairman Stark stated, "Lack of coverage for prescription drugs remains one of the largest gaps in Medicare coverage. Over one-third of the elderly have out-of-pocket drug costs exceeding $650 per year."

On May 30, 1991, Mr. Stark introduced H.R. 2500, the Medicare Prescription Drug Act of 1991, which would provide coverage for outpatient prescription drugs under Part B of Medicare, effective 1993.

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND

According to a 1989 report to Congress issued by the Department of Health and Human Services, the average, non-institutionalized Medicare beneficiary used an average of 15.3 prescriptions per year in 1987. Average usage increased somewhat with age. The average number of prescriptions per persons has also increased over time. Individuals with functional impairments (measured by two or more limitations in their activities of daily living) used an average of 26.2 prescriptions per year. Individuals in poor health used an average of 31 prescriptions per year.

Most prescriptions for the elderly are not covered by insurance. Only 30 percent of prescriptions filled in community pharmacies for the elderly were billed to Medicaid or other third party payers. An unknown number of the remaining prescriptions may have been submitted to insurers by the patient.

The cost of prescription drugs has been rising rapidly. Between 1980 and 1987, the average annual cost of prescription drugs for the elderly increased by 14 percent per year. The Health Care Financing Administration has estimated that the average prescription in 1993 will cost $24.26. Using 1987 usage rates, the average annual cost of prescription drugs per person for the elderly will be $371 in 1993.

(MORE)

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Tuesday, June 25, 1991, to Robert J. Leonard, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

Chairman STARK. Good morning. The Subcommittee on Health of the Committee on Ways and Means will begin hearing this morning a Medicare prescription drugs drug benefit proposal under H.R. 2500, the Medicare Prescription Drugs Act of 1991.

Unlike most other health care expenses, prescription drugs expenses are neither covered by Medicare nor by many of the medigap policies. Many senior citizens require multiple prescriptions each year in order to manage their health contracts and to treat acute problems. Without insurance, seniors are forced to pay substantial out-of-pocket sums to buy the medications they need to survive or maintain their health.

In 1992, one-third of seniors will spend over $650 per year for prescription drugs; one in five will spend over $1,000 a year.

In some cases, drugs costs are so high that beneficiaries simply take a chance and do without their prescribed medications simply because they cannot afford the expense.

I recently received a letter from Anne Parks of Mableton, Ga. Mrs. Parks is disabled and faces multiple health problems, including lupus, renal failure, diabetes, and arthritis. While her husband is employed as a clerk earning $25,000 per year, she has prescription drug costs of over $12,000 a year.

She writes, and I quote:

> The time is approaching when I will have to choose which of the drugs I can afford to take, and since all of my medications are life sustaining, I may very well die because of insufficient funds. I am terrified.

While the need for prescription drug coverage is clear, Congress has not yet been able to meet the challenge in 1991.

A Medicare prescription drug benefit was one of the first program modifications considered after enactment of the Medicare program more than 25 years ago. The Senate passed a prescription drug benefit in 1972, but the benefit was never enacted.

After years of experience with public coverage of prescription drugs through Medicaid and the Veterans' Administration, Congress enacted a new Medicare drug benefit as part of the Medicare Catastrophic Coverage Act in 1988. Unfortunately, the legislative history of this distinguished piece of legislation is all too well known to members of this subcommittee.

On May 29, I introduced H.R. 2500, the "Medicare Prescription Drug Act of 1991." This bill would provide benefits for those Medicare beneficiaries with prescription drug costs exceeding $650 per year.

While the cost of this bill is high, I say that this cost simply demonstrates the burden of prescription drugs on the elderly and disabled, and emphasizes the need for a drug benefit.

I urge my colleagues to join this effort to include coverage for outpatient prescription drugs for Medicare.

Mr. McGrath.

Mr. MCGRATH. Thank you, Mr. Chairman.

Let me congratulate you on calling this hearing on a benefit on which I have some substantial interest. My mother has been deceased for a year now. I probably could have used this benefit substantially during the last couple of years of her life. We do have a program like this in New York State. The deductible in that pro-

gram, I think, is $600 a year. One of the complaints that I get about the State program is that, while it is good for those who have expenses of $600 or more, which is a substantial amount of money per month for any kind of consistent drug program, most of the people who are in the Medicare age group, at least in the younger Medicare age group, don't come near the $600 or $650 per year deductible. Thus, there would be no benefit to some of these people who would be paying. I suspect we all recognize the problem that we went through with the minimum drug program that we had in catastrophic and the fact that everybody wants these benefits but very few are willing to pay.

I am looking forward to hearing from our witnesses how they envision this program should be worked and financed. Hopefully we could at least have enough catastrophic coverage so that the woman from Georgia paying $12,000 a year for drugs could be helped to some extent through some sort of Medicare-funded program.

I am interested in this program. I am anxious to hear what our witnesses have to say and see what happens. Thank you so much.

Chairman STARK. Thank you.

At this time, I would like, without objection, to ask unanimous consent to insert in the record the statement of Senator David Pryor, the distinguished Senator from Arkansas and chairman of the Senate Special Committee on Aging, who has prepared testimony for this hearing and ask that it be inserted. Without objection his testimony will appear in the record.

[The statement of Senator Pryor follows:]

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United States Senate
SPECIAL COMMITTEE ON AGING
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STATEMENT OF SENATOR DAVID PRYOR (D-Ark)
Chairman, U.S. Senate Special Committee on Aging

submitted to the
U.S. House of Representatives
Ways and Means Subcommittee on Health
June 11, 1991

THE MEDICARE PRESCRIPTION DRUG ACT of 1991 (H.R. 2500)

Mr. Chairman, I want to commend you for holding today's hearing and introducing the Medicare Prescription Drug Act of 1991. There's a famous Yogi Berra saying that applies here: "This feels like de-ja vu all over again." Congress has repeatedly debated the merits of enacting a Medicare drug benefit since 1965 -- some 26 years ago -- and did add a limited drug benefit as part of the Medicare Catastrophic Coverage Act (MCCA) of 1988. We all know the fate of that law, but there are few people in this nation who would disagree that one of the most unfortunate outcomes of the repeal is that Medicare patients continue to remain victimized by the high costs of outpatient prescription drugs.

Mr. Chairman, I applaud your continued interests in assuring that elderly Americans have access to affordable health care, including prescription drugs. During my absence from the Senate, I am continuing to follow developments in this area, and felt strongly about submitting a statement.

The high costs of prescription medications in the United States have, as we all know, forced the elderly to make choices between such necessities of life as food and drugs. Indeed, skyrocketing prescription drug prices have precipitated a public health crisis in this country, and there are no signs of relief in sight. Therefore, the addition of a Medicare drug benefit makes logical sense for many reasons.

First, for 75 percent of our nation's elderly, prescription drugs represent their highest out-of-pocket medical expenditure. Medicare, Medicaid, and other third party insurers have provided good protection for the elderly against hospital and physician bills, but there is a paucity of private insurance plans that offer prescription drug coverage. Those that do generally have high additional premiums, deductibles and cost sharing, still making them prohibitively expensive for the average elderly citizen.

Second, it makes good health sense to insure that the good care our nation's elderly receive in a hospital or physician's office continues outside the hospital or the physician's office. Once discharged from a hospital, elderly that are unable to afford to fill prescriptions will too frequently end up back in the hospital for additional, more expensive treatment. All of us receive letters from seniors who relate their own personal stories of how they have to skip doses of their medication to make it last longer or split a tablet in half to stretch out their prescription because they cannot afford to buy their drugs. This situation is unacceptable to me, as I know it is to you.

Having said this, Mr. Chairman, I believe that any Medicare drug benefit should incorporate mechanisms that control the overall costs of the prescription drug component of the program as well as promote access to, and the appropriate utilization of, prescription drugs for the elderly.

One of the reasons that Congress repealed the entire MCCA was the ballooning estimates of the drug benefit. Congressional estimators could not get a good handle on the costs of the drug benefit in the outyears. There was not so much a problem in estimating prescription utilization or the number of eligible beneficiaries, but in determining the inflation rate on existing pharmaceuticals and the introductory price of new pharmaceuticals. That is because MCCA did not have a mechanism to control the overall rate of growth in prescription drug expenditures for the Medicare program.

I suggest that the Committee consider a similar cost control mechanism that was enacted for the Medicaid prudent pharmaceutical purchasing program as part of the Omnibus Budget Reconciliation Act (OBRA) of 1990 (P.L. 101-508). In OBRA, Congress enacted a program to insure that the $5 billion dollar Medicaid prescription drug program will receive a fair deal on the tremendous amount of pharmaceuticals that it purchases each year. Up until last year, Medicaid was not receiving any volume discounts from drug manufacturers, in spite of the fact that Medicaid is the single largest prescription drug program in the country.

In addition to requiring that drug manufacturers give Medicaid a minimum discount or a manufacturer's "best price" in the market, the law provides that Medicaid's price for pharmaceuticals can inflate no higher than the Consumer Price Index (CPI-U). The importance of this indexing provision cannot be overstated. Without such an indexing mechanism, there was no guarantee that drug manufacturers would not simply raise prices in order to make up for the rebates that they have to give to Medicaid.

Since 1980, drug prices have been inflating not once, not twice, but three times the rate of the CPI-U. Last year's call by Congress for drug manufacturers to show restraint in pricing policies have obviously fallen on deaf ears. As the attached chart shows, in the first quarter of 1991, drug price inflation was a startling five times the rate of general inflation.

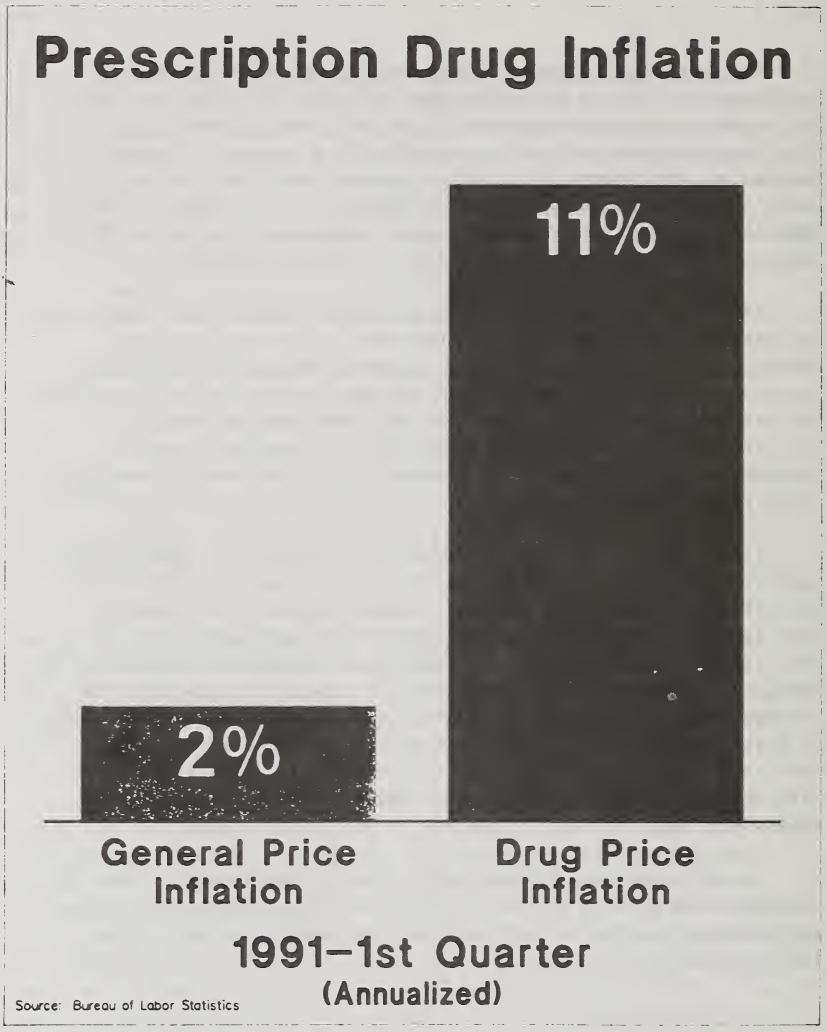
Medicaid now constitutes about 15 percent of the prescription market in the United States, and is the single largest payer for prescription drugs in the country. If a Medicare drug program were enacted, the federal government's pharmaceutical purchasing power would be increased even more -- perhaps up to 45 or 50 percent of the market -- and we would be able to negotiate sizeable discounts with drug manufacturers. This would not only insure a fair deal for Medicare and Medicaid, but would allow federal health dollars to be spent on expanding access and coverage, and not on excessively high prescription drug prices.

The new Medicaid law also provides for the establishment of a comprehensive program of Drug Use Review (DUR). Congress provided for a similar program as part of MCCA, and I was pleased to see that your proposed legislation provides for a program to assure appropriate drug prescribing and dispensing practices. We are all aware that a large portion of our elderly population take multiple medications, and that adverse reactions from drugs are one of the leading causes of hospital admissions for elderly patients.

Reducing the occurrence of drug problems before they happen, and making prescribers aware of them after they happen to avoid reoccurrence, is what I believe will result from the Medicaid DUR provisions. Our health care system can save hundreds of millions of dollars in reduced hospitalizations and other medical care interventions if this type of program was extended not only to federal government health care programs, but other managed care and third party programs as well.

Lastly, Mr. Chairman, I believe it is important to emphasize that we must find a way to contain health care costs not only for our public programs, but also for all Americans who desperately need relief from sustained prescription drug price inflation. In that vein, it is my intention to continue to question why the average American pays 50 percent more for the same drugs than the average European and 60 percent more than the average Canadian. It is high time we address this issue as well as the fairness of continuing to give the drug industry generous tax breaks and write-offs when all we get in return are higher prices on existing drug products.

I look forward to working with you to find answers to these questions and to make substantial progress towards addressing these disturbing drug industry pricing practices and making medications more affordable and available.


Prescription Drug Inflation
11%
2%
General Price Inflation
Drug Price Inflation
1991–1st Quarter
(Annualized)
Source: Bureau of Labor Statistics

Chairman STARK. Mr. Cardin.

Mr. CARDIN. I applaud and congratulate you for holding these hearings. Prescription drugs should be included in Medicare. I think it is a disgrace that we do not include those benefits under our programs for the elderly and disabled. So I congratulate you for holding these hearings in order for us to discuss in this committee and in Congress the ways in which we can provide prescription drugs under Medicare.

Like New York, we have a program in Maryland that is very, very successful. It has proven that we save money, and that we are providing better care for our elderly by providing prescription drugs.

I think it is vital that we find a way to include prescription drugs under Medicare. I am very pleased that you are holding these hearings. Let me caution the two real difficult issues we must confront. First, cost containment, how to keep the cost reasonable for the Federal Government to be able to afford. And second, how do we finance it. You are suggesting perhaps increasing premiums. Is that the proper way to do it? Should we be looking for some general funds? We know about the Budget Act of last year and we must comply with it.

I hope the witnesses will address not only the need for prescription drugs in Medicare but how should we finance it and how can we incorporate cost controls into any act that we discuss.

Chairman STARK. I thank the gentleman for his very perceptive comments.

Our first panel this morning includes three witnesses from groups representing the Medicare beneficiaries. Ruth Scarborough is a member of the board of directors, American Association of Retired Persons; Max Richtman, executive vice president, National Committee to Preserve Social Security and Medicare; and Lucia DiVenere, public policy associate, Families USA.

Welcome to the committee. Your written testimony will be made part of the permanent record. It would be helpful to the committee if you would care to summarize your statements orally or expand on them if you choose. Please proceed in the order in which you were introduced.

Ms. Scarborough, welcome to the committee. Would you like to start?

STATEMENT OF RUTH SCARBOROUGH, MEMBER, BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF RETIRED PERSONS

Ms. SCARBOROUGH. Good morning, Mr. Chairman and members of the subcommittee. I am Ruth Scarborough with the board of directors of the American Association of Retired Persons.

I thank you for the opportunity to testify here today. With older Americans purchasing the greatest share of prescription drugs of any age group, the association is committed to promoting access to safe, effective, and affordable prescription drugs. In this regard, enactment of a Medicare prescription drug benefit continues to be a high priority for the association.

AARP provides information to its members on how to shop around for the best prescription drug prices and advice on how to

better manage and use those medications. But judging from the hundreds of phone calls and letters the association receives on the diminishing affordability of prescription drugs, it is evident that AARP's efforts to help older Americans to be wise consumers can't keep pace with the current rapid pharmaceutical price increases.

Clearly, the continuing rise in prescription drug prices over the last decade significantly reduces access to needed drug therapies, a problem worsened by diminishing private insurance coverage for outpatient prescription drugs. For millions of older Americans living on fixed incomes who pay for all or part of their prescriptions out of pocket, high drug costs lead to difficult choices—choices between food on the table, oil for the furnace, or purchase of a life-sustaining medication. From 1980 through 1990 prescription drug prices soared 150.6 percent compared with a general inflation rate as measured by the CPI of 58.6 percent. Even more striking is that drug price increases far exceeded increases in the Medicare component of the CPI, which measured 117.4 percent over the same period.

In the United States of America we pay some of the world's highest prices for our prescription drugs. All 12 European Community countries control drug prices in one fashion or another and the price of a brand named drug product in those countries is on average one-third less than the U.S. price.

The drug industry argues that high prices are necessary to recover their research and development investments and to cover the costs of research for medications that never make it to the market. Other less responsible actions not mentioned by the drug industry, however can also significantly contribute to escalating prices, such as questionable promotional activities or excessive and sustained industry profits.

A better balance between drug company profits and affordability of prescription medications is essential. AARP believes that a reasonable investment in research and development is warranted but excesses are irresponsible. Older Americans are impacted the most by high prescription drug prices and heavy usage.

In the United States, persons age 65 and older represent only 12 percent of the population, yet in 1988, they accounted for 34.3 percent or $9.1 billion of the $26.5 billion spent on retail prescription drugs.

In 1987, the average annual number of prescriptions for those aged 65 and up who were noninstitutionalized was 15.1 as compared to 3.8 for those under 65 with 80 percent using at least one prescription drug. For 1990, drug expenditures for persons aged 65 and older are estimated to be $12.1 billion for an average of $379 per person.

Additionally, according to a survey AARP conducted over the last several weeks, one-third of those aged 65 and older said that compared to other health care costs, paying for prescription medications is a really major problem.

These access problems are compounded by the financial situation of older Americans and the lack of affordable insurance coverage. What private insurance coverage is available is expensive with high premiums, substantial deductibles, costly coinsurance, and policy limits such as a $500 cap on what the policy will pay.

High prices, heavy use and the absence of affordable insurance coverage have converged to make prescription drugs the highest out-of-pocket medical expense for three out of four older Americans.

Further, prescription drug prices significantly affect the behavior of older Americans. I see the light is on.

Thank you very much. I appreciate your efforts and hope that we can really accomplish something with this.

Thank you.

Chairman STARK. Thank you very much, Ms. Scarborough.

[The prepared statement follows:]

Statement of Ruth Scarborough, Member of the Board of Directors, American Association of Retired Persons

Good morning, Mr. Chairman and members of the subcommittee. I am Ruth Scarborough, a member of the Board of Directors of the American Association of Retired Persons (AARP). AARP appreciates the opportunity to testify today on the need for an outpatient prescription drug benefit under the Medicare program. With older Americans purchasing the greatest share of prescription drugs, the Association is keenly interested in pharmaceutical issues. In particular, AARP is committed to promoting access to safe, effective, and affordable prescription drugs.

In this regard, AARP provides a variety of assistance on prescription drugs to its members. For example, among AARP publications is The Smart Consumer's Guide to Prescription Drugs, featuring (1) tips on how to shop around for the best prices, (2) information on generic drugs, and (3) advice on how to better manage and use medications. Nonetheless, judging by the hundreds of phone calls and letters the Association receives on the diminishing affordability of prescription drugs each year, it is evident that AARP's efforts to help older Americans to be wise consumers cannot keep pace with the rapid pharmaceutical price increases that they must endure.

Clearly, the unyielding escalation in prescription drug prices over the last decade has significantly reduced access to needed drug therapies -- an access problem exacerbated by diminishing private insurance coverage for outpatient prescription medications. Few insurance companies find drug coverage profitable in a market beset by adverse selection and uninhibited price increases, and even fewer are willing to cover the growing number of newly released "wonder drugs" that are marketed at breathtakingly high prices.

The cumulative result has been a rapid acceleration in out-of-pocket costs for consumers using prescription drugs. For millions of older Americans living on fixed incomes, high drug costs can lead to difficult choices -- such as a choice between food on the table, oil for the furnace, or the purchase of a life-sustaining drug.

Escalating Prescription Drug Prices

Prices for prescription medications began to rapidly escalate in the early 1980s and have far outpaced overall inflation ever since (see Chart I). From 1980 through 1990, prescription drug prices soared 150.6 percent, compared with a general inflation rate (as measured by the Consumer Price Index -- CPI) of 58.6 percent. Even more striking is that drug price increases far exceeded increases in the medical care component of the CPI, which measured 117.4 percent over the same period.

Consumers are well aware of prescription drug price increases. In a June, 1991 survey sponsored by AARP, 34 percent of the respondents of all ages taking prescription medications said that, compared to the cost of other household items, the cost of their prescription(s) increased substantially over the last couple of years. (This number grew to 50 percent for respondents age 65 and up.)

Notably, many other industrialized nations have not experienced the same rapid escalation in prescription drug prices. In fact, in the U.S. we pay some of the world's highest prices for our prescription drugs, perhaps even subsidizing lower prices in countries with strict price controls. On average, drug prices in the United States are:

- more than twice as high as prices for the same products in strict price-control nations (e.g., Greece, Spain, Portugal, and France);

- about 26 percent higher than prices in nations with limited price controls (e.g., The United Kingdom, Ireland, and Denmark); and

- slightly higher than prices in other nations without price-control systems (e.g., West Germany).

All 12 European Economic Community countries control drug prices in one fashion or another, and the price of a brand name drug product in those countries is, on average, one third less than the U.S. price.

The drug industry argues that high prices are necessary to recover their research and development investments and to cover the cost of fruitless research for medications that never make it to market. Other less responsible actions not mentioned by the drug industry, however, can also significantly contribute to escalating prices, including:

- Questionable promotional activities, including direct-to-consumer advertising and thinly disguised research programs that, in reality, are used as marketing tools (e.g., as part of a settlement on a drug promotion violation, the FDA recently required Bristol-Myers to send a letter to the 8,000 recipients of their publication, "Oncology Commentary," explaining that only "favorable opinions and data" on their products were included in the studies they published.)

- Development and marketing of high-priced new drugs, the therapeutic advantages of which are not significantly different from existing, lower-priced medications but which often drive-up the prices of the older drugs.

- Excessive and sustained industry profits despite repeated warnings by Congress and a continuous barrage of appeals by consumers for more reasonable prices. (In 1989, the pharmaceutical industry realized a 15.5% after-tax profit on sales, nearly three times that experienced by all manufacturing enterprises in the U.S.).

From the consumer's perspective, a better balance is necessary between drug company profits and the affordability of prescription medications to the patients who need them. A reasonable investment in research and development is warranted, but excesses that unnecessarily add to drug prices are irresponsible when a patient's access to needed drug therapies is jeopardized as a result.

Disproportionate Impact on Older Americans

Older Americans account for the greatest number of patients whose ability to purchase needed drug therapies is jeopardized by persistently high prescription drug prices and heavy utilization:

- In the U.S., persons aged 65 and older represent only 12 percent of the population, yet in 1988 they accounted for 34.3 percent ($9.1 billion) of the $26.5 billion spent on retail prescription drugs (HCFA, 1990).

- In 1987, the average annual number of prescriptions for those aged 65 and up (noninstitutionalized) was 15.1 (compared to 3.8 for those under 65) with 80 percent using at least one prescription drug (NCHSR, 1989). Utilization for those institutionalized is even greater.

- The mean expenditure per prescription drug for this group was $16.89, up 110 percent from 1980, and the mean annual expenditure per person on prescribed medications was $248.10 -- a 154 percent jump from 1980 (NCHSR, 1989).

- For 1990, drug expenditures for persons age 65 and older are estimated to be $12.1 billion, for an average of $379 per person (HCFA, 1990).

Additionally, according to AARP's June, 1991 survey, 33 percent of those age 65 and older said that, compared to other health care costs, paying for prescription medications is a major problem. Only 21 percent of those under age 65 gave a similar response.

The access problems that arise out of the high cost and heavy utilization of prescription drugs are compounded by the financial situation of many older Americans, which leaves them with little means to pay for the high price of prescriptions:

- In 1989, the median household income of persons age 65 and over was $15,771, less than half that of those between the ages of 15 and 64 ($33,019).

- Older persons have the highest poverty rate of any adult age group (11.8 percent), and older women living alone experience an exceptionally high poverty rate of 23 percent.

- Forty percent of older Americans have a family income at or under 200% of poverty.

In addition to the poor financial condition of many older Americans, the problem of higher out-of-pocket costs for their prescription drugs becomes more severe due to the lack of affordable insurance coverage. A 1989 AARP national survey of noninstitutionalized persons age 65 and older found that only 27 percent had Medicare supplemental insurance with some type of drug coverage. More recently, our June, 1991 survey found that 39 percent of respondents age 65 and older had no prescription drug insurance coverage from any source, compared to 29 percent for those under age 65.

The tremendous growth in the price of pharmaceuticals significantly contributes to the reluctance of private supplemental policies to cover drugs -- and what little coverage is available is expensive due to high premiums, substantial deductibles, costly coinsurance (e.g., 50 percent), and policy limits (e.g., a $500 cap on what the policy will pay).

High prices, heavy utilization, and the absence of affordable insurance coverage have converged to make prescription drugs the highest out-of-pocket medical expense for three out of four older Americans.

The Consequences of Unaffordable Medications

High prescription drug prices significantly affect the behavior of older Americans. According to a report by the Public Health Service, 15.5 percent of elderly patients who require prescription drugs said that they are unable to pay for them. High costs can also encourage modifications to drug regimens (e.g., two pills a day instead of the four prescribed) that can seriously reduce a prescription's effectiveness. In 1986, an AARP national telephone survey found that the second most frequently cited reason -- up from fourth in 1982 -- given by older Americans for not getting a prescription filled as ordered by their doctors was the cost of the drug.

More recently, AARP's June, 1991 survey found that 14 percent - one in seven - of the respondents age 65 and older had decided on at least one occasion to either not fill a prescription, stop taking a prescribed drug, or reduce the dosage due to the cost of the drug. Clearly, cost contributes significantly to a patient's non-compliance with recommended treatment.

The proper use of safe and effective drugs can be among the most cost-effective forms of medical care, and increasing non-compliance with prescribed drug regimens could increase physician visits and even hospitalization, thereby driving up overall medical costs. Unfortunately, elderly patients cannot put off buying essential drugs until there are price reductions at their local pharmacy or until they can save more money. Simply put, rapid increases in prescription drug prices are precluding access to a needed form of medical care for many older persons.

AARP Supports Medicare Coverage of Prescription Drugs

AARP is committed to comprehensive reform of our health care system so all Americans, regardless of age, are assured access to affordable, quality acute and long-term care services. The Association recognizes, however, that incremental steps may be necessary to move toward a comprehensive health care system that will provide universal access and allow for meaningful cost control. In this regard, AARP strongly supports greater access to and cost containment of prescription drugs, especially for older Americans -- the group most vulnerable to losing access to prescription medications due to high cost and heavy utilization.

To ensure greater access, AARP believes it is time to seriously consider methods to reduce out-of-pocket costs for prescription drugs. The current system of "what the market will bear" for drug pricing, combined with the absence of an adequate and affordable private insurance option, deny too many older Americans access to essential, often life-saving, products. Given the poor financial situation of many older Americans, their heavy utilization of prescriptions drugs, and rapid price escalations, AARP believes an expansion of Medicare benefits to cover outpatient prescription drugs is warranted.

AARP, however, is well aware of the concern that a major Medicare expansion would generate in both the Administration and Congress due to its impact on the Federal budget. Medicare is already one of the fastest growing parts of the budget and, given the current deficit situation, many policymakers will not be enthusiastic about "fueling the fire." Nonetheless, as access to needed drug therapies is diminished among older Americans, Medicare costs will increase due to heavier utilization of medical care paid by Medicare (e.g., physician visits, hospitalization, surgery, etc.) -- costs that could be avoided if appropriate prescription medications are made more accessible to beneficiaries.

To minimize the impact on the budget, AARP strongly believes that any Medicare drug benefit must include effective cost containment mechanisms. Congress repealed the Medicare Catastrophic Coverage Act, including the outpatient prescription drug benefit, in part due to the fear of out-of-control costs. A Medicare drug benefit that does not adequately control costs will soon become unaffordable and suffer the same fate. In AARP's view, the most practical cost containment strategy is one that utilizes the aggregate purchasing power of Medicare beneficiaries through the Medicare program to negotiate down pharmaceutical prices.
In terms of paying for a Medicare drug benefit, the Association believes that financing should be broadly-based through a mechanism similar to the traditional method of financing Medicare Part B benefits -- financing that spreads the cost of the program across the entire taxpaying population. This method is fair considering that many people under age 65 will benefit to the degree that their parents and grandparents will be less dependent on them for financial assistance in the purchase of prescription

drugs. Also, it is important to remember that more affluent older persons are paying income taxes which contribute to the 75% of Medicare Part B funding that comes out of general revenues.

In addition, when younger Americans become eligible for Medicare in the future, and become more susceptible to high drug costs, they too will benefit from the lower individual cost associated with broad-based financing. Also, to the extent that employers provide prescription drug coverage to their employees, a significant portion of private insurance coverage for drugs for those under age 65 is currently subsidized by all taxpayers through the tax exclusion of employer-provided benefits.

In addition, AARP believes that out-of-pocket expenses (e.g., premiums, coinsurance, and deductibles) for a Medicare drug benefit should be reasonable and affordable, reflecting the financial situation of many older Americans. Further, the administration of the benefit should be structured to promote efficiency and include effective drug utilization review. Mismedication and over-medication are serious problems among older Americans leading to unnecessary side-effects and hospitalizations. Any program that expands access to prescription drugs should also focus on reducing the incidence of inappropriate medication through a review of prescription drugs for potential adverse reactions and over-medication.

Representative Stark's Proposal

AARP applauds Representative Stark for his leadership in introducing "The Medicare Prescription Drug Act of 1991." In general, the Association believes that both the benefit and financing structures proposed in Congressman Stark's legislation meet most of AARP's guidelines for a Medicare drug benefit as discussed above. The Association recommends the following as a means to strengthen the bill:

1. Enhanced cost containment provisions that, among other things, better reflect the aggregate purchasing power of Medicare beneficiaries and the Medicare program to drive down escalating drug prices and assure affordable premiums.

2. Broadly-based and stable, tax revenue financing that is sufficient to pay for the benefits and that also adheres to the budget enforcement provisions incorporated in OBRA '90.

3. More fully developed drug utilization review provisions that assure substantial reductions in mismedication and over-medication of prescription drugs among older Americans.

4. Greater emphasis on encouraging administrative efficiency in beneficiary services, provider compliance, and program monitoring.

AARP would be pleased to work with Chairman Stark to incorporate these recommendations and build support for a Medicare prescription drug benefit in the Congress, the Administration and, most importantly, among the general public.

Conclusion

The combined effects of high prices, heavy utilization, and the absence of affordable insurance coverage for prescription drugs have significantly reduced access to needed drug therapies for many older Americans, making them more vulnerable to unnecessary and more expensive medical care. AARP is a strong advocate of comprehensive health care reform. The Association, however, recognizes the importance of incremental steps that can bring us closer to reform, and an expansion of the Medicare program to

cover outpatient drugs is a major and much needed step in the right direction.

AARP applauds the leadership of this subcommittee in addressing this issue. We look forward to working with you to achieve passage of a Medicare prescription drug benefit.

D-4-STARK-6/3

Chairman STARK. Mr. Richtman.

STATEMENT OF MAX RICHTMAN, EXECUTIVE VICE PRESIDENT, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

Mr. RICHTMAN. Mr. Chairman, my name is Max Richtman, executive vice president of the National Committee to Preserve Social Security and Medicare.

I am pleased to be here today to comment on H.R. 2500 which would expand Medicare part B to include an outpatient prescription drug benefit.

The high cost of medicine is one of the Medicare issues about which our members write to us most often. The miracle of modern drugs has become the miracle that many cannot afford. Clearly, something must be done to help beneficiaries pay for their costly prescriptions. Your legislation, H.R. 2500, would go a long way to address this serious need.

We are told by some of our members that they fail to buy their medicine as prescribed simply because they can't afford it. Prescription drug costs represent a growing out-of-pocket expense for Medicare beneficiaries and at least 15 percent of seniors report they are unable to pay for their medications. Mr. Chairman, your legislation estimated that as many as 35 percent of beneficiaries will benefit even with the $650 deductible which is twice the percentage of the beneficiaries helped by the Catastrophic Drug Act prescription drug benefit.

The proposal calls for a flat $50 increase in the deductible every year. In the first year, this amounts to a 7.7 percent increase, but the percentage will decrease with each year.

The approach taken in your legislation making the prescription drug benefit coverage an integral part of the part B program promises to keep intact the social insurance concept of the Medicare program. Even so, the 20 to 25 percent increase in the part B premium and the $650 deductible may be a hardship for some beneficiaries.

We believe it is essential to seek our members' opinions about such Medicare expansion. It is important to determine whether Medicare beneficiaries are able and willing to pay the $6 to $8.50 monthly premium increase. And what about beneficiaries who already have drug coverage through private insurance? What are their concerns? We plan to poll our members on these and other questions to get a current update on their experiences and needs.

There are many provisions in your bill we support. First, we appreciate the built-in incentive for the higher administrative allowance for participating pharmacists; however, the National Committee would urge that pharmacists be required to participate. The use of balance billing by nonparticipating pharmacies invites overcharges. If a limit is placed on actual charges, it necessitates establishing a system of monitoring, policing, and enforcement of charge limit violations.

Considering the escalating costs of drugs, cost containment should be considered a central piece of any new drug legislation. Last year's OBRA 1990 established a rebate program under which the Medicaid program is supposed to save billions of dollars. Per-

haps a similar rebate program including an enforcement mechanism under Medicare could be incorporated into H.R. 2500.

We support the electronic claims processing included in H.R. 2500. Incentives should be provided for pharmacies to use state-of-the-art on-line, real-time electronic claims management. With this type of equipment, the pharmacist not only can check right away to see if the beneficiary has met the deductible, but can do an instant drug review and file the claims immediately. The Medicaid 1990 law called for at least 10 statewide demonstration projects to evaluate the efficiency and cost effectiveness of such systems. A Medicare prescription drug program should build on the information gained from these demonstration projects.

Review of beneficiaries' drug regimen should be a strong element of any new prescription drug initiative, and we commend you for including it in H.R. 2500. One recent study found that one in five people over age 60 has had an adverse reaction to a prescription drug and for 43 percent of those affected, it caused serious problems.

Finally if new Medicare benefits duplicate existing benefits in employer-provided insurance or individual medigap insurance, such private coverage should be adjusted to fit the benefit. A strong maintenance-of-effort provision requiring either a reduction in premiums or new benefits could satisfy this concern.

The National Committee recognizes that numerous problems surround the issue of prescription drugs, such as availability, cost, and the medical necessity for each prescription drug. It is clear that there is a need for education and reform. We see your legislation as the focus for the debate.

Again, we appreciate your leadership on this issue, Mr. Chairman, and as always, the National Committee looks forward to working with you as this bill moves through the legislative process.

Chairman STARK. Thank you.

[The prepared statement follows:]

Statement of Max Richtman Executive Vice President, National Committee To Preserve Social Security and Medicare

Mr. Chairman, my name is Max Richtman, Executive Vice President of the National Committee to Preserve Social Security and Medicare. I am pleased to be here today to comment on H.R. 2500 which would expand Medicare Part B to include an outpatient prescription drug benefit. The high cost of medicine is one of the Medicare issues about which our members write to us most often. The miracle of modern drugs has become the miracle that many cannot afford. Clearly, something must be done to help beneficiaries pay for their costly prescriptions. Your legislation, H.R. 2500 would go a long way to address this serious need.

Non-compliance. We are told by some of our members that they fail to buy their medicine as prescribed simply because they can't afford it. Prescription drug costs represent a growing out-of-pocket expense for Medicare beneficiaries and at least 15 percent of seniors report they are unable to pay for their medications.[1] This is demonstrated by the fact that Medicare beneficiaries used an average of 15.3 prescriptions a year in 1987, and beneficiaries with disabilities used an average of almost 24 per year.[2] One National Committee member, Mrs. R. of Jacksonville, Florida, reported that she reduced her $232 monthly prescription bill to $112 by taking one pill instead of the prescribed two of one prescription and going without an $84 a month prescription to counteract a necessary blood thinning drug. In such as Mrs. R's case, the savings could lead to serious internal hemorrhaging costing the Medicare program even more in hospitalization. Another member from Chandler, Oklahoma, confided that she lives only on Social Security and half of her check goes to pay for her drug bill.

Increasing Cost of Prescription Drugs. Prescription drug prices rose at a pace which exceeded inflation three to one between 1981 and 1988. While this rapid growth is estimated to slow down in future years, according to CBO, some individuals find it difficult to manage his or her budget for medication. As Mr. R. from Greensboro, North Carolina relays his frustration, "the last bottle of Tagamet was $63.85--yesterday it was $71.40. On a fixed income--by the time you pay $398 for medicine every month, you don't have much left."

Americans spend more for prescription drugs than citizens of any nation in the European Economic Community (EEC). In fact, the average drug prices paid by American consumers are 54 percent higher than the average for all EEC nations.[3] Sor people will go to great lengths to get prescription drugs at a cheaper rate. One gentlemen, Mr. A. from Ashland, Oregon, stocked up on Tagamet when he traveled t Mexico. In Mexico he paid only $16.35 for the same prescription he would pay $53 in Oregon. Other people save money by using mail order companies and by buying in large quantities.

Many hospitals, HMOs and other large health care providers form buying groups to ask drug manufacturers for reduced prices in exchange for the products being listed as a preferred product by the provider. This can be done safely because many different drugs are used to treat the same medical condition. However, few beneficiaries are able to take advantage of these lower prices at their corner drug store. For example, National Committee member Mrs. L. of East Wareham, Massachusetts, has great difficulty understanding why her Trilisate prescription costs her $52 at the drugstore when her daughter, a nurse, was able to obtain the same prescription for only $8 at the hospital where she worked.

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[1] Prescription drug prices: are we getting our money's worth? A Majority Staff Report, Special Committee on Aging, U.S. Senate, August 1989.

[2] Moeller and Mathiowetz (1989). Prescribed medicines: A summary of use and expenditures by Medicare beneficiaries. National Medical Expenditure Survey Research Findings 3, National Center for Health Services Research, DHHS Publication No (PHS) 89-3448

[3] Skyrocketing prescription drug prices: turning a bad deal into a fair deal. A Majority Staff Report, Special Committee on Aging, U.S. Senate, January 1990.

Medicare Prescription Drug Benefit Act of 1991.

Mr. Chairman, your legislation, H.R. 2500, estimates that as many as 35 percent of beneficiaries will benefit--even with its $650 deductible--which is more than twice the percentage of beneficiaries of the 1988 Medicare Catastrophic Coverage Act prescription drug benefit. The proposal calls for a flat $50 increase in the deductible every year. In the first year, this amounts to a 7.7 percent increase, but the percentage will decrease with each year.

Financing. The approach taken in your legislation making the prescription drug coverage an integral part of the Part B program promises to keep intact the social insurance concept of the Medicare program. Even so, the 20 to 25 percent increase in the Part B premium and the $650 deductible may be a hardship for some beneficiaries.

We believe it is essential to seek our members' opinions about such Medicare expansion. It is important to determine whether Medicare beneficiaries are able and willing to pay the $6 to $8.50 monthly premium increase. And what about beneficiarie who already have drug coverage through private insurance? What are their concerns We plan to poll our members on these and other questions to get a current update on their experiences and needs.

Participation. We appreciate the built-in incentive of a higher administrative allowance for participating pharmacists, however, the National Committee would urge that pharmacists be required to participate. The use of balance billing by non-participating pharmacies invites overcharges. If a limit is placed on actual charges it necessitates establishing a system of monitoring, policing and enforcement of charge limit violations.

Cost containment. Considering the escalating costs of drugs, cost containment should be considered a central piece of any new drug legislation. Last year's OBRA 19 established a rebate program under which the Medicaid program is supposed to save billions of dollars. Perhaps a similar rebate program including an enforcement mechanism under Medicare could be incorporated into H.R. 2500.

Electronic claims filing. We support the electronic claims processing included in H.R. 2500. Incentives should be provided for pharmacies to use state of the art on-line, real-time electronic claims management. With this type of equipment, the pharmacist not only can check right away to see if the beneficiary has met the deductible, but can do an instant drug review and file the claims immediately. The Medicaid 1990 law called for at least 10 statewide demonstration projects to evaluate the efficiency and cost-effectiveness of such systems. A Medicare prescription drug program should build on the information gained from these demonstration projects.

Drug Review. Review of beneficiaries' drug regimen should be a strong element of any new prescription drug initiative, and we commend you including it in H.R. 2500. One recent study found that one in five people over age 60 has had an adverse reaction to a prescription drug and for 43 percent of those affected it caused serious problems.[4] It is estimated that between three and eight percent of all hospital admissions and between 12 and 15 of admissions among seniors each year may be due to adverse drug reactions.[5]

The 1990 Medicaid prescription drug program requires a prospective drug use review. States are encouraged through an enhanced federal match to acquire electronic equipment. This makes it possible at the time and place of sale to screen for potential drug therapy problems due to duplications, drug-disease contra-

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[4]University of Southern California, Los Angeles, 1991.

[5]Nolen L, O'Malley K. Prescribing for the Elderly, Part I: Sensitivity of the Elderly to Adverse Drug Reactions. Journal of the American Geriatric Society, 1988.

indications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, drug-allergy interactions, and clinical abuse or misuse.

In addition, this review program establishes standards for counseling of individuals by the pharmacist. For example, a pharmacist must offer to discuss with the customer or the caregiver the dosage, how best to administer the drug, what happens if a dosage is missed, the duration of drug therapy, special directions and precautions for preparation and use of the drug, the most common side effects or interactions and therapeutic contra-indications that could be experienced by the consumer. Also the beneficiary should be informed about proper storage and refills.

While a prospective review is extremely important in weeding out therapeutic mistakes, a retrospective review also should be built into the system, as it was in last year's Medicaid drug law. A retrospective review of claims data could help identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care, among physicians, pharmacists and individuals receiving benefits under this program.

Duplication of Coverage. Finally, if new Medicare benefits duplicate existing benefits either in employer provided insurance or individual medigap insurance, such private coverage should be adjusted to fit the Medicare benefit. A strong maintenance of effort provision requiring either a reduction in premiums or new benefits could satisfy this concern.

Conclusion. The National Committee recognizes that numerous problems surround the issue of prescription drugs, such as availability, cost, and the medical necessity for each prescription drug. It is clear that there is a need for education and reform. We see your legislation as the focus for the debate.

Again, we appreciate your leadership on this issue, Mr. Chairman, and as alway the National Committee looks forward to working with you as this bill moves throug the legislative process.

Appendix
Member Stories

1. When her medicine bill got up to $232 per month, Mrs. M. R. of Jacksonville, Florida, simply could not afford to take the number of pills her doctor prescribed. Mrs. R. lives on a $495 monthly Social Security check. She has arthritis throughout her body, has a serious heart condition, lives with dangerous blood clots in her legs and suffers from fibrositis. Besides her heart medicine she takes a blood thinner and several other prescriptions. In order to get her monthly prescription down to a more affordable $112 per month she is taking one anti-inflammatory and painkilling drug per day instead of the prescribed two pills a day. More dangerously, she is simply not taking an $84 a month medication prescribed to counteract the blood thinner and prevent internal hemorrhaging. Mrs. R who is still paying off hospital and doctor bills of more than $1,000 from last year, said "I just pray to God that I will not hemorrhage to death."

2. Mrs. E. L. from W. Wareham, Massachusetts, is a 70 year old widow living on Social Security and a private pension totalling $1,000 per month. Suffering from rheumatoid arthritis and high blood pressure, she takes six prescription drugs. One of her prescriptions, Rheumatrix costs $35 for a week's supply of three pills--almost $12 a pill.

Mrs. L. has great difficulty understanding why her Trilisate prescription costs her $52 at the drugstore when her daughter, a nurse, was able to obtain the same prescription for only $8 at the hospital where she worked--before the hospital changed its policy last December about prescriptions for family members.

3. Mrs. M. N., a 77 year old widow from Altoona, Pennsylvania, has a serious heart problem, arthritis, glaucoma and cataracts. She takes at least 14 and sometimes more prescriptions at any one time. Mrs. N. is fortunate to live in Pennsylvania where the PACE program pays all but $4 per prescription. However, just paying $4 per prescription still means a monthly drug bill of between $56 to $72--a hardship for this woman whose income is below the poverty level. This remarkable woman, who has had four heart attacks and triple bypass surgery, is daily picked up by a county van that takes her to a local nursing home where she plays piano for residents for hours on end.

4. Mrs. F. F. of Beecher City, Illinois, is an 80 year old widow of 36 years, with only her $500 Social Security check to live on. She suffers from arthritis and stomach ulcers. She is on three prescription which would cost her $150 per month if she took the prescribed amounts. However, instead of taking two of her ulcer pills a day at a cost of $1 per pill, she saves $30 a month by cutting the dosage in half and risking chronic ulcer problems.

5. Mrs. S. B. from Fort Worth, Texas, wrote to the National Committee to complain bitterly about her husband's expensive heart medicine which totals $346 per month out of their small Social Security check. Her letter ends, "is there nothing that can be done about the cost of staying alive?"

6. Eighty-one year old Mrs. E. N. from North Branch, Minnesota, lives on $349 in Social Security, supplemented with a small pension of less than $100. After she pays her $245 rent, electricity, phone bill, $50.40 for insurance and gas for the car, there is not enough to pay for medicine. "Medicine is terrible, I have to put drops in my eyes morning and night as I have cataracts and glaucoma and this small bottle about 1 1/2 inch high costs over $36. I also have an ulcer that acts up once in awhile and had to get some capsules--15 for $59.75 and I think that's terrible."

Chairman STARK. Ms. DiVenere.

STATEMENT OF LUCIA DI VENERE, PUBLIC POLICY ASSOCIATE, FAMILIES USA

Ms. DIVENERE. Thank you, Mr. Chairman.

My name is Lucia DiVenere. I am public policy associate of Families USA, a nonprofit advocacy group, and I am pleased to have the opportunity to present our views on your proposal, H.R. 2500, the Medicare Prescription Drug Act of 1991, to include outpatient coverage of prescription drugs in the Medicare program.

Prescription drugs account for the largest out-of-pocket health care costs for three out of every four older Americans. While the average senior spends about $300 a year on drugs, one out of five spends in excess of $500 a year. The elderly as a group are estimated to spend $9.1 billion on prescription drugs a year, more than twice that of the general population. In fact, while the elderly make up 12 percent of the total U.S. population, they account for 34 percent of all retail drug expenditures.

While extensive private and public coverage is available to cover health care costs seniors incur for hospitals, physicians, and other services, very little coverage is available to cover the costs of prescription drugs. The Medicare program, for example, will cover the cost of drugs provided on an inpatient basis, but very limited coverage for outpatient drugs. Most Medicare supplemental insurance, or medigap policies, also do not cover this heavy expense. And while every State Medicaid program offers prescription drug coverage, the program only covers these costs for one-third of all poor seniors. Thirty-seven States cover these costs for the medically needy, but 17 States cover them for the categorically needy only.

This problem is exacerbated by the high rate of price inflation in the pharmaceutical industry. Between 1985 and 1989, the Consumer Price Index rose 2.7 percent, while retail prescription drug prices increased 12.2 percent. Looked at another way, between 1981 and 1988, drug prices increased 88 percent, compared to a 28-percent increase in general prices for consumer goods.

Limited coverage options and repaid price inflation combine to leave the elderly with high prescription drug costs extremely vulnerable.

In 1988, Congress moved to fill this gap in coverage by passing the Medicare Catastrophic Coverage Act. This bill expanded the Medicare program to include coverage for catastrophic medical expenses and prescription drugs for more than 32 million elderly and disabled individuals. The drug program contained in this legislation, which would have gone into effect on January 1 of this year, would have provided an estimated $3 billion in benefits to close to 6 million seniors and disabled individuals. Despite the repeal of the 1988 act, the need for coverage of prescription drug still exists and will only worsen as drug costs continue to escalate.

I would like to voice my support for your legislation to restore the prescription drug benefit to the Medicare program. This bill would make coverage of prescription drugs a regular part of the Medicare part B program and provide benefits to 35 percent of the Medicare population. I would like to suggest several ways in which

I believe the bill could be improved to better serve low income seniors, and all those in need of this important benefit.

Specifically, all pharmacies, both participating and nonparticipating, should be required to accept Medicare payment rates as payment in full. Beneficiaries should not be subject to balance billing for prescription drugs.

Low income protections should also be further refined. For example, the proposed $650 deductible for this benefit will effectively be beyond the reach of many lower income seniors and disabled individuals in need of drug coverage. The financing method to which the committee ultimately agrees should also protect Medicare beneficiaries with low incomes. One possible way of achieving this protection is to extend the out-of-pocket protections of the QMB program.

The qualified Medicare beneficiary—QMB—program was established by Congress in the Medicare Catastrophic Coverage Act to require the Medicaid program to cover the out-of-pocket costs—premiums, deductibles, and copays—associated with the Medicare program for Medicare individuals with incomes below the Federal poverty line, and with assets below twice the SSI allowed amount. In last year's OBRA this protection was extended, for the part B premium only, to individuals with incomes up to 120 percent of the Federal poverty line by 1995. The asset test remains the same.

While under your proposal, the QMB program would presumably already cover the increase in the part B premium associated with this new benefit, the program could be further enhanced to cover the cost of the prescription drug deductible and copays for QMB's with incomes between 100 and 120 percent of the Federal poverty line as well.

As the subcommittee moves to consider ways to include outpatient prescription drug coverage under the Medicare program, I urge you to also consider meaningful cost containment as a critical design element for a successful program. The Medicare program should not become an open-ended funding stream for pharmaceutical manufacturers. Continued high price increases would not only find their way into increased premiums, deductibles, and other out-of-pocket costs for the intended beneficiaries, but would also jeopardize the program itself.

In this context, we recommend that you consider the measures included in the last year's Omnibus Budget Reconciliation Act to control prescription drug costs in the Medicaid programs. The Medicaid Prudent Pharmaceutical Purchasing Act, introduced by Senator Pryor and Congressman Wyden and included in OBRA 1990, is expected to save the Medicaid program $3.4 billion in 5 years—$1.9 billion for the Federal Government and $1.5 billion for the States—through reducing drug prices paid by the Medicaid program.

Currently, the Medicaid program is one of the Nation's largest purchasers of prescription drugs, accounting for 12 to 15 percent of sales, and pays a total of $5 billion a year in prescription drug costs. In 1989, the Senate Special Committee on Aging conducted an exhaustive series of hearings on the reasons for high prescription drug costs in the United States and the effect of this cost spiral on public programs that pay for these drugs. During the hearings, it became evident that the Medicaid program—a program

for the poor that is experiencing such difficult financial straits that many States are being forced to consider ways to reduce services—was paying 40 to 70 percent more than other payers for the same drugs.

The 1990 act rectifies this situation by requiring pharmaceutical manufacturers, beginning this year, to offer the Medicaid program the lowest price it offers other buyers, or a 12.5-percent discount for brand name drugs, whichever is lower. The lowest price is indexed for the Medicaid program to hedge against large price hikes every year and the percentage discount increases to 15 percent in 1993. Generic drugs are discounted to 10 percent in 1991 to 1993 and 11 percent thereafter.

The manufacturers' incentives to enter this arrangement are that, first, no Federal matching payments are available for the drugs of manufacturers that do not enter into these rebate agreements, and second, participating manufacturers will have all their drug products covered by the Medicaid program. This is a significant incentive since many State programs have restricted their coverage to only certain drugs in an attempt to control costs.

Families USA fully supported this bill. Public programs should not be paying top dollar for products and services that are available at much lower costs elsewhere on the market. Plus, the new law also limits prescription drug inflation in the Medicaid program to the rate of increase in the CPI–U, which is the measure of general market inflation. Given that prescription drug prices have been rising at three times the rate of inflation, this limit should help ensure significant savings for the Medicaid program. Limiting program costs increases to an index also helps guarantee against manufacturers raising prices significantly to other buyers, effectively raising their lowest price in order to limit the rebates they must pay the Medicaid program.

Unfortunately, since enactment, there have been isolated reports of manufacturers attempting to raise the price they used to give their best customers in order to recoup the rebates they owed the Medicaid program. The General Accounting Office is currently investigating how widespread this practice is and reportedly have not found any signs of systematic abuse.

Other meaningful cost control devices not in OBRA 1990 are consistent with high quality care and include the use of therapeutic formularies, which are widely used in this country in HMOs and are also used extensively in the Canadian health care system. Instituting formularies would, of course, mean that manufacturers would not have all their drug products covered by Medicare.

Another way to achieve cost savings and guard against cost shifting would be to adopt an all-payer health care system. Many other nations, including Canada and some European communities, negotiate successfully with drug manufacturers for discounts. In fact, the Office of the Inspector General of the Department of Health and Human Services recently reported that the average American pays 55 percent more than the average European for drugs and 62 percent more than the average Canadian.

Cost control and savings provisions similar to these should be seriously considered as ways to help ensure the success of a Medicare prescription drug benefit.

Mr. Chairman, I appreciate your interest in our comments on your bill and I look forward to working with you on this important issue.

Chairman STARK. I want to thank the panel. I must say as Senator Pryor "deja vu all over again." But the first letter I ever received from a constituent regarding this bill said, "I don't like paying even $5.00 a month for a benefit I already get free from"—wherever they got it, Kaiser or their own retirement fund. "Don't you remember what happened to you in the catastrophic bill when I would have had to pay $800."

This person is as misinformed now as they were then but it did occur to me that there would be some resistance.

Now an alternative to that which would be cosmetic would be to make this voluntary. Arguably you could not make it voluntary for a very long period of time. You would have to make it voluntary as part B, so that you sign up when you become eligible or you pay a premium to get back in.

As a political move, will this be sufficient to diminish the chorus of outcries among the seniors who would resent or oppose paying even $5 a month in an added part B type premiums or would that be limited to those few very fortunate seniors who have this coverage through a funded program from a previous employer?

There is no sense in going through a drill which has a remote possibility of passage to begin with but only to have busloads of people coming into my district letting me know what a low-life I am for even promoting this legislation.

Can each of you respond to that? Would they pay say $5 a month?

Ms. SCARBOROUGH. Yes, I think they would. I think people have been startled in the past couple of years since the downfall of catastrophic. I think they have seen their health care costs go up as much as 50 percent during the last year or two.

I think they are certainly going to be willing to accept something like that. We are doing a survey to find out how people feel about it. I don't really see a terrible problem, not from the people that I am talking to.

One thing I might address is your thought about a voluntary program. This is all a good way to get people to buy initially. My concern is that people will wait until they are really going to be faced with something.

Chairman STARK. You would not allow that. In the first 6 months when you become eligible you would have to choose whether or not to go in. You could make it voluntary or if you did it the way they described, then people would wait until they had an expensive prescription to sign up and then the costs would be too high.

Max.

Mr. RICHTMAN. Your proposal of making the program voluntary initially would probably make it more acceptable to some people. I think you raised the critical question and that is there still would be some adverse selection.

Then it is important to look at the impact on the financing, the premium, and the amount paid out of the Treasury and see where the numbers fall. As far as whether people would find it acceptable

to pay an additional premium, I think the approach that you are taking is, as I said in my testimony, in keeping with the social insurance concept of Medicare where everybody is participating. The 75 percent contribution from the Treasury is made by all people who pay taxes. What we would like to do and intend to do is conduct some polls of our members on this specific proposal.

We also have an ongoing series of focus groups around the country. We would be more than happy to plug this into that process so we can find out what our members think before anything is passed and those people affected feel a part of the process.

Chairman STARK. Ms. DiVenere.

Ms. DIVENERE. I think that making the program voluntary at least in the initial stages would probably help overcome any political problems but I don't think it gets you out of the problem of adverse selection because you would have the 32 million current Medicare enrollees who would be able to choose at the time.

I think you would see significant adverse selection that would probably not work to the benefits favor. In terms of whether or not people would be willing to pay $5 or so a month, Families USA supports progressive financing of the Medicare program and its benefits. We would prefer to see financing along those lines.

If we could not we would like to talk more about the protections for lower income individuals. One thing that weighs in your favor is that private coverage through medigap is getting scarcer as well.

Chairman STARK. Do you find the approximately $5 flat part B premium objectionable?

Ms. DIVENERE. It is better than some of the premiums we have been faced with in recent years. I think when you are talking about people living very close to the poverty line or below that, any increase is a difficult increase. Some individuals would come out net winners if they did not have to face the deductible and got coverage for prescription drug costs for $5 a month.

Those are the kinds of things that need to be weighed at this point. We will still be talking about making the QMB work better. We will be putting out a report next week that shows it to be weak protection as it stands.

Chairman STARK. I take it you are not enthusiastically endorsing this kind of a program and would not unless it had no cost to the seniors.

Ms. DIVENERE. Not at all. I don't mean to imply that. We support this bill. We supported the surtax financing in catastrophic. We don't shy away from asking seniors to pay for benefits that they benefit from or asking seniors with higher incomes to bear more of the financing burden than seniors with lower incomes.

When you look at the flat premium, we want to talk about protections for people with lower incomes from those flat premiums. When you talk about the rest of the 75 percent of the program costs, we would hope that financing would be constructed in a way that does not fall disproportionately hard on lower income individuals.

Chairman STARK. Thank you.

Mr. McGrath.

Mr. MCGRATH. Thank you, Mr. Chairman, and thank you for the testimony. It was great.

I have the same lingering effect of catastrophic. I supported it all the way to the end and then I had to go home and face the people who this bill was intended to help. We made a mistake in catastrophic in terms of who was to benefit and who was not.

There are those who have already purchased medigap policies. Also, in my particular area of the country, there are a lot of retirees who worked as teachers, Government employees, civil servants, and other, and they have ample health care benefits in retirement, including prescription drugs. If I went into any one meeting of those who would be interested in this particular subject, I can assure you that a lot of the people who would be vocal on this issue would be those who already had the benefit and therefore didn't want to participate in the payment for those who may not. We need to have a larger pool of people in order to finance the benefit for those who this was intended to serve. We really can't just let everybody off the hook who perhaps would want to be let off the hook and who are served adequately by other insurance coverage.

I don't know how to get around that. Frankly, I would hate to go through the same drill with the 550 people, the AARP group, that I met with in Valley Stream, Limbrook, or other areas of my district. I intend this summer during the break to meet with approximately 10,000. I am going to senior citizen clubs, beach programs, and whatever. This is one of the things I am going to talk to them about. I am going to ask them to raise their hand if they are willing to pay $8.50 on their part B premium per month for a prescription drug plan.

I will let you know how I feel about the program after I talk to them. The bottom line is that I recognize the need for this. As I said, I have not only my mother but other people who have responded to me and written to me over the last 20 years about the need. This is a great need, perhaps not for a majority of the people who are 65 and above, but a need for those who really do need it.

I wonder how we reconcile that. How do we get people who perhaps already have it, maybe don't even need it, to contribute to a program that is very much needed by a large group, maybe the most elderly? I am wondering whether you could react to that concern.

Mr. RICHTMAN. Congressman, it is no easy task to do what you are talking about. The option in making the program voluntary perhaps would address some of the concerns of your constituents. But I think beyond that it is important, as the process goes on, as this legislation and other health legislation moves through Congress, to make sure that people in your district and around the country are informed and educated about what exactly the proposal will cost, who will pay, and what will be covered. I think one thing that can be done and the chairman of this subcommittee has gone a long way on this point in his bill, is to make the bill include a lot of other attractive features that will help people, even if they have some coverage.

This would not address everything that you are raising. But if a proposal such as this can really get hold of the cost of distribution and keep those costs down and deal with some of the other issues within the prescription drug world, I think it can be sold, at least

people will be encouraged to participate because of the other benefits which may be tangential to the other coverage.

Ms. DiVenere. A lot of this reminds me of the work we are doing with the National Association of Insurance Commissioners in developing the new medigap policies.

I serve on the advisory committee to the NAIC. We have spent the last many months on developing what those products would look like, including what the prescription drug coverage would look like. After our best negotiations on what the policies should look like, what the benefits should look like, and what they will cost, we asked the NAIC to poll seniors nationwide, through a scientific sampling, to get an idea of what seniors see as their real needs and what they are willing to pay for coverage.

Not surprisingly, everybody wants every single benefit that can be conceived of and they want to pay next to nothing for it. Most of the time they think they are paying next to nothing for whatever coverage they have. There are not easy answers to the question of how do you try to put in place the right sort of benefit that will truly fit the people who need it in the face of people who already have the coverage or who may think they have the coverage sometimes even if it is a phantom benefit. I think it is a difficult question.

I don't think it is easy to put that policy in place.

Mr. McGrath. You have pricked my interest. You work with the Association of Insurance Commissioners. In my other life where I was a ranking member in the New York State Assembly so many moons ago, we put into effect pilot projects on this subject, home health care, and others. We figured in some cases some of the coverage we were putting in place would take the load off acute care.

Well, that did not happen. What happened was that it just expanded the expense of everything. I am just wondering whether or not there are any statistics through this organization or through States like Maryland and New York and others when they have this kind of program. Also, I wonder whether or not the anticipated cost of the program has been what the actual cost is, or has it been driven way out of the ball park?

Ms. DiVenere. My familiarity is more with the State Medicaid drug programs. I can speak more to that than some of the other purely State programs that you are referring to. I know that costs have been increasing and that was part of the reason Congress passed the Medicaid cost control mechanisms. A lot of things can be done to control costs, including volume discounts, and having the Federal Government being a better negotiator for prices.

The Medicaid program purchases about 15 percent of all retail drugs and were getting no discount whereas smaller purchases were getting significant discounts. Congress moved to change that. Therapeutic formularies are also important. There are a number of things that should be done and that haven't been fully utilized yet. A major part of the problem is increasing costs from the manufacturers of these drugs themselves.

I think Congress should go ahead with this sort of benefit, but only with strict cost controls in place as an integral part of this program.

Mr. McGrath. Thank you.

Chairman STARK. Mr. Cardin.

Mr. CARDIN. While Mr. McGrath holds his summer meetings with his seniors, they may differ on whether we are willing to pay $5 to $8 a month for prescription drugs, but if Ray asks whether the seniors are satisfied by how the Federal Government has acted to control the cost of prescription drugs, I think you will get unanimity among the groups that there is a concern about the escalating costs of prescription drugs.

As the Federal Government gets more involved in reimbursements for prescription drugs, that is if we enact our chairman's bill, there will be more interest by the Federal Government in placing caps or cost controls on prescription drugs under the Government program.

One of my concerns is that there will be cost shifting. The employer-based plans again will, to a certain degree, subsidize the Government reimbursement plans on prescription drugs.

Ms. DiVenere, one thing that intrigues me about your statement is that you talked about an all-payer system. I assume you are referring to prescription drugs. I would like to know if you have ways in which an all-payer system could work. Would there be a national control on prescription drugs with which all payers would comply? Would it be different in different regions? Do you have any further suggestions on how an all-payer system could work for prescription drugs, because I agree that would stop cost shifting and may very well be a system that could be used for overall cost controls.

As you address that, we also want to make sure we don't stop the opportunities for new drugs to be developed. We have the best incentives for the development of drugs in this country that have performed miracles for our citizens and we don't want to discourage that.

Ms. DIVENERE. Right. We have been spending a lot of time in the last few years looking at more significant overall changes that could be made to the health care system. The reference to my testimony to an all-payers system is more in the context of a larger scope of reform to the health care system in which all payers would pay the same rates for all types of services including prescription drugs.

Your idea of putting in place an all-payer for prescription drugs alone I think could still work. I think I would want to play with the idea a little bit. The idea of putting it all in place service-by-service has some real potential.

To some degree we have seen that a little bit with hospital costs in that some insurers try to—I guess it goes both ways— in some cases, the private insurers try to mimic the controls in terms of hospitals and physicians and in some cases, the Federal Government tries to mimic the private market for controls as well. It is happening too slowly to help the ills we currently see. My testimony was more specifically talking about in the context of a larger reform that that would also help to address the cost shifting issues that would be prevalent in prescription drugs.

Mr. CARDIN. If we moved prescription drugs under Medicare with Federal control over its cost, we may be just accelerating the undue cost increase of private employer based plans because their plans

will not be subject to the same cost controls that we have at the national level.

Regardless of whether we move to an overall reform of our system or move in piecemeal we have the same issues.

Ms. DiVenere. One of the proposals we have in a package that looks at larger health care reform issues is a proposal that private employers who use private insurers should be able to require health providers to accept the Federal payment rates or rates bases on the Federal reimbursement mechanisms as a condition of their Medicare participation.

What we found in discussing this with small employers is oftentimes they lack the market clout to require providers to accept those rates. One of the things we have been proposing to Congress is to insure that providers as part of their Medicare participating agreement be required to accept those fees when they are requested.

Mr. Cardin. Let me follow up on whether there is a possibility of reaching a consensus in AARP or the elderly community, Mrs. Scarborough, for a prescription drug component to Medicare, totally financed through the premium. I have heard from my senior groups that they are very strongly in favor of any expanded benefits being based upon sharing between the premium and other outside revenues similar to how part B is financed today and that they would resist expansion of Medicare with 100 percent of the premiums paid by the elderly themselves.

Your testimony seems to indicate that we should be able to frame a program for prescription drugs totally financed by the beneficiaries themselves. Am I reading your testimony correctly?

Ms. Scarborough. Perhaps I should add that I agree with your statement that this should be a part of Medicare overall and everybody should be paying for this. A lot of people are covered by Medicare who are not really in that very senior group. There are a lot of other beneficiaries.

It has a long-range effect. I would like to leave my children and grandchildren feeling assured that they would not have to pick up the tab for me if I was really having problems. They would have an assurance by whatever they are paying in through their taxes, et cetera, they would be paying a part of that. I understand that. I think that they eventually are going to be beneficiaries of this themselves so there is a long-range effect.

Chairman Stark. Mr. Coyne.

Mr. Coyne. Thank you, Mr. Chairman.

Is it safe to conclude that each of you have experienced instances where beneficiaries have been denied prescription drugs because of an inability to pay for them?

Mr. Richtman. We have an appendix to our testimony that lists about half a dozen of our members who have contacted us on that very point.

Mr. Coyne. Are there any of you who believe the $650 deductible is too high and we ought to make it lower?

Ms. Scarborough. That is probably true.

Ms. DiVenere. Families USA argues that it could put the benefit effectively out of the reach of low-income individuals. My testimo-

ny suggests ways to fill that gap for people below 120 percent of the Federal poverty line.

Mr. COYNE. So in your testimony you have outlined ways we may be able to protect those at the lower income level?

Ms. DIVENERE. That is right.

Chairman STARK. I appreciate the panel's work. If we are going to do something I don't think we would have any trouble among those of us here on either side of the aisle and the panel in determining what the benefits ought to be.

My bill is strangely silent on the $30 billion that it would cost us over 5 years out of general revenues to fund the difference. We could pick up a good bit from the pharmaceutical industry by doing a reverse R&D tax rather than give them an R&D credit or cut out the money spent in Puerto Rico by the R&D.

Considering the huge profits they make they probably ought to arguably cough up a little more than the rest. Other than that, I am a little short on ideas for raising the $30 billion. Your help in that regard will be most appreciated.

Thank you for joining us today.

Ms. SCARBOROUGH. Thank you.

Mr. RICHTMAN. Thank you.

Ms. DIVENERE. Thank you.

Chairman STARK. Our next witness is Dr. Stephen Long, a senior economist with the Rand Corp.

Steve, welcome back to the committee. It is nice to see you again. Would you proceed to summarize or expand on your written statement in any manner that you are comfortable.

STATEMENT OF STEPHEN H. LONG, PH.D., SENIOR ECONOMIST, RAND CORP.

Mr. LONG. Mr. Chairman, I am pleased to be here today to offer the committee my thoughts on the problem of prescription drug costs for the elderly and the disabled. My testimony relies heavily on work I did while I was at the Congressional Budget Office and while I served as the first, and also the last, Executive Director of the Congress' Prescription Drug Payment Review Commission.

Today I would like to comment on three things: prescription drug spending by Medicare enrollees; the difficulty individuals face in obtaining private insurance coverage for this spending; and some public policy options for remedying the problem.

The average annual spending for prescription drugs by Medicare enrollees is nearly $500 in 1991. This compares to an annual outlay of about $360 for the part B premium and, roughly, a $700 average medigap premium. Therefore, drugs represent an important source of out-of-pocket costs for enrollees.

Table 1 shows that there is a considerable spread of individual experiences around this average. At the low end, 18 percent of enrollees spend nothing for prescriptions in a year. At the high end, 27 percent will spend over $600, but they will account for 74 percent of total spending.

So about a quarter of the people will account for three-quarters of the spending.

[Table 1 follows:]

TABLE 1.—DISTRIBUTION OF SPENDING ON PRESCRIPTION DRUGS FOR MEDICARE ENROLLEES, CALENDAR YEAR 1991

Spending categories	Percentage of enrollees	Percentage of spending	Percentage of spending over $600
0	18	0	0
$1 to $299	36	9	0
$300 to $599	19	17	0
$600 to $899	10	15	7
$900 to $1,199	6	14	15
$1,200 and above	11	45	78
Total	100	100	100

Note: Average spending for all enrollees is $483.

Source: Congressional Budget Office, "Updated Estimates of Medicare's Catastrophic Drug Insurance Program," October 1989.

Mr. LONG. This type of distribution of spending, characterized by many people with relatively low spending and only a few with very high spending, appears to be the kind that gives rise to insurance. That is, by pooling their risks, people can make their spending more predictable, and therefore easier to budget.

Let's turn to briefly review the actual experience with insurance in this area.

Both private and public insurance contribute to covering some Medicare enrollees for the costs of prescription drugs, but many others are left without good options for insurance. Although the underlying data are not as good as I would like, table 2 summarizes the supplementary coverage people have to Medicare and offers a stylized description of the typical drug benefits offered.

About 40 percent of Medicare enrollees have very good drug coverage. They are covered by Medicaid, State pharmaceutical assistance programs, or private retiree group plans. These insurance sources offer early coverage with little or no cost sharing and they generally have no maximum limits.

Another 40 percent purchase individual medigap policies, most of which do not cover prescription drugs. Moreover, these individual policies that include drugs often offer very limited coverage. Finally, 20 percent of enrollees have no source of supplementary coverage, even for hospital and physician care.

Observers of the medigap market contend that prescription drug coverage, once a common benefit, has been on the way out of those packages over the last decade. The reason they cite is unfavorable experience with adverse selection. That is, people with high drug costs are more likely to enroll in the plan when a drug benefit is an optional benefit. But when they do, they drive up the average cost of the group, which in subsequent enrollment periods will lead to further erosion of the low spenders from the plan. As this dynamic proceeds, the drug option is eventually dropped.

[Table 2 follows:]

TABLE 2.—CURRENT SOURCE, IF ANY, OF PRESCRIPTION DRUG INSURANCE FOR MEDICARE ENROLLEES

Source of supplementary insurance	Typical drug benefits	Percentage of Medicare enrollees
Medicaid, State pharmaceutical assistance, or private retiree health plan.	First-dollar coverage or deductible joint with medical services; nominal copayment to 20 percent coinsurance; no maximum.	40
Individual medigap plan	Generally none; if offered, has separate deductibles, coinsurance, and maximum.	40
No supplement to Medicare	None	20

Source: Descriptions of benefits based on published plan descriptions and telephone interviews with insurers. Percentages based on tabulations of 1987 National Medical Expenditure Survey.

Mr. LONG. For adverse selection to occur, the insured individual must possess more information than the insurer about his expected spending. In the case of drugs for Medicare enrollees, this condition is of differential information often satisfied. The reason is that much of the use of drugs in this population is to treat chronic conditions. So, many enrollees have high and predictable spending from year to year. It is no wonder, then, that medigap insurers have trouble maintaining stable risk pools of voluntary enrollees for prescription drug insurance.

There are several things that Congress might do that would help correct the adverse selection problem with respect to prescription drugs in the individual insurance market for Medicare supplements. As is almost always the case, each has some advantages and some disadvantages.

One approach would be to require that all medigap policies include a reasonable prescription drug benefit; and of course that the premiums be raised sufficiently to finance that new benefit. This option would focus the change on enrollees who have shown an inclination to protect themselves from unexpected health care costs, but who now have trouble buying drug coverage. It would leave unaffected all those who have retiree coverage or Medicaid that already provides these benefits, either free or at no cost, thereby avoiding some of the redistribution that led to so much concern under the Medicare Catastrophic Coverage Act. Of course, this would be of no help to the 20 percent of enrollees who have no form of Medicare supplement. Because it would continue decentralized purchasing, it would also offer no help in controlling the rapidly rising costs of prescription drugs.

Another approach would be to offer some Federal assistance to the States to engage in pharmaceutical assistance programs for those enrollees who are above Medicaid eligibility standards but whose income is still deemed inadequate to handle the risk of high drug costs. In contrast to the first option, this approach would pick up many of the people who have no Medicare supplement, as well as many others who might find burdensome the extra premiums under a required medigap drug coverage approach. The down side of these voluntary enrollment programs is that they require some external source of revenues to finance their subsidized benefits. Some States have handled this by earmarking lottery or gambling revenues to these programs, but not all States have these sources available to them—especially in the current climate.

A final approach, one which is no stranger to this committee, is make prescription drugs a part of Medicare. The obvious advantage of this approach is the achievement of universal enrollment. Another potentially important advantage of this approach is that the market power of Medicare as a buyer might offer opportunities to slow the rate of growth of drug spending. The obvious difficulty is how to finance the new benefits when roughly 40 percent of the enrollees have excellent benefits now, but pay little or nothing for them.

Thank you. That concludes my prepared statement. I would be happy to take any questions.

Chairman STARK. Thank you. Some of the other testimony, I suspect what we will hear today will support free market forces. I am not sure quite what those are. They are cosmic, I think, or competition as a way to hold down prescription drugs prices.

Now, as an economist, how do these arguments settle with you? Is the market for prescription drugs competitive at the retail level? Does my mother shop around? Do the senior citizens shop or is it kind of a cliff, either you have the money and buy it or you don't? How do you assess market forces as a way to hold down drug costs?

Mr. LONG. One of the interesting challenges of being Executive Director of that short-lived Commission was to have the opportunity to think about this industry and how one might pay for drugs. What was interesting was, at the retail market level, I think things are reasonably competitive. There are a lot of retail establishments, they come in and out of business and they advertise lost leaders. Usually when we are thinking about price controls of one sort or another and how to get a handle on cost containment, we think about reimbursement levels and providing the service.

In this case, we have a bunch of competitors. The problem is, that is not where the issue is. The issue lies back one step in the market, in the market power of those who provide the goods to those competitive retailers. That is the pharmaceutical industry.

Chairman STARK. Not the pharmaceutical manufacturers?

Mr. LONG. It is the pharmaceutical manufacturers. That is the issue where the pricing controls are at issue. They are monopolists for a period of time after they introduce the drug because the Government gave them the money openly. That was part of the bargain to develop these drugs, put up all the up-front money are then turn around and reap some of the return.

It is a very complicated market to control. You want to provide incentives for R&D and give fair prices. As you look across to Europe, those who are purchasing power of all the people in the country, they are getting better prices than what we are getting here.

Chairman STARK. Let's talk about that for a moment. Why are prices 60 percent higher here than in Canada for the same drugs, for the same style of practice of medicine? How do you, as a economist account for that?

Mr. LONG. Because of all the little buyers from the retail level who are going to the industry, the fact that in some countries you have centralized buying and in others decentralized. Here we do decentralized. That is the same reason private insurers cannot get good deals out of hospitals.

Chairman STARK. Don't they have the same market distribution in Canada as they have there?

Mr. LONG. My understanding is that they have some serious control over prices there.

Chairman STARK. It sounds like free enterprise to me. Canada is not a socialist country, is it?

Mr. LONG. Not at last look.

Chairman STARK. It is very much more conservative than ours.

You were involved in the first estimates of the costs. We will also hear predictions of doom to a financial system of the United States. It confuses me again as to how, if we pay for pharmaceuticals through some kind of a Medicare plan, that the country could get into much greater recession than it is in by having my mother pay for her own pharmaceuticals.

But that is the type of reasoning we will hear. Most of the criticism is that we tremendously underestimate the cost of the drug benefit. What about the data we have now that was not available to us a couple of years ago or are we still just guessing all of this stuff in the blind.

Mr. LONG. We have better data now than we did when the first estimates were done. That is why the egg was all over our faces when we gave you the second estimates. We got better data and we had the nerve to raise our estimates to about twice the first levels.

Those data were largely based on a single national survey reflecting 1987 prices. What has happened since then, when we listened to anecdotes and collect what shreds of information are available, is that things are going up very fast.

But on a national basis, how fast is hard to tell. If I were still back at CBO, I would be nervous at doing these estimates all over again because now I might be taking a 1987 baseline survey which might have some underreporting and we were extrapolating for the future without the good hard facts.

I would advise you to be cautious against the estimates you are getting, not that they are not the best. When the Government is not buying all this stuff, then the data we have to rely on are much weaker.

Chairman STARK. Thank you.

Mr. McGrath.

Mr. MCGRATH. Dr. Long, we are talking about providing some sort of prescription drug benefit to our senior citizens. Would you subscribe to the theory that there is an industry out there, whether it be an insurance industry or a pharmaceutical industry, and that rather than try to eliminate that industry, we should try to work it in order to attain the goals that we have in mind?

Mr. LONG. The option I offered to regulate medigap was in fact an option. I am not sure how sellers of medigap would respond, but I think thy would agree that it is selection that is causing the problem.

Whether they would agree to put a drug benefit in all plans or not, I am not sure, but their actuaries would say that would solve the adverse selection problem.

Mr. MCGRATH. You look at that as an opportunity to market their goods rather than——

Mr. LONG. That is right.

Mr. McGrath. That is what I figured.

There is a $650 deductible and 20 percent coinsurance for outpatient prescription drugs under H.R. 2500. Do you view this as a cost-sharing requirement that would inhibit overutilization? Your own new statistics say that there is a $500 average cost per senior in the country now. The $650 would affect how many seniors? You said 18 percent off the bat.

Mr. Long. Those who do not use any.

Mr. McGrath. How many would use less than $650?

Mr. Long. Well, I had 1991 data and the committee is using 1993 data in the estimates it is presenting. Those numbers are consistent. My numbers were about 37 percent over $600, so it would be 25 or 23 over $650 in 1991 dollars, but because of how fast this thing is growing, the 1993 dollars the committee is using will give you a higher percentage.

Mr. McGrath. The question I posed to the last panel regarded the efficacy of cost projections. As you have pointed out, we had an interesting experience with catastrophic.

Has it been generally the experience in health care costs over the last decade or so that programs that were anticipated to be at a certain cost level increased significantly?. Obviously they have been increased, but have they increased to the extent which would make them prohibitive to even think about?

Mr. Long. The experience in the State pharmaceutical assistance program that was raised a while ago, as I understand it, is also one of costs going up somewhat faster than people expected. In part, it is because they did not anticipate how fast drug prices would be going up and in part because they did not understand how fast the utilization of the people enrolled would be going up.

Those are the same surprises. It is the same surprise CBO got caught in in the cost estimates for catastrophic. Those were the trends of the mid-1980s, faster price increases and faster utilization.

Mr. McGrath. Those could be predicted. The thing that is tougher to predict is that you would think when New York State gets into buying drugs or insuring drug costs, that perhaps they could, by themselves, drive the costs down. It didn't seem to happen.

Mr. Long. My experience, and knowing most estimators and knowing actuaries as well, they do their best not to let policymakers be fooled by expected savings by discounts and cost containment mechanisms and the like.

They are usually conservative because they are nervous.

Mr. McGrath. You said Medicare might operate as a buyer to slow the drug spending.

Mr. Long. That is different than New York State. There you are talking about a very large buyer in the market. Therefore, I think you would have some significant opportunities that running the State pharmaceutical assistance program in New York does not allow you.

Chairman Stark. Mr. Cardin.

Mr. Cardin. Dr. Long, on table 2 of your presentation, you break out the number of Medicare enrollees that have first dollar or comparable type of support for prescription drugs.

Do you know how many of the 40 percent of the enrollees that have significant prescription drug coverage have that through private retiree health plans?

Mr. LONG. The private retiree number is somewhere in the 30 percent of the 40 range. About three-quarters of that are private group retiree programs.

Mr. CARDIN. Do you know whether that number is decreasing or increasing?

Mr. LONG. It has been increasing over the last couple of decades, significantly, because this has become a far more common benefit. The people enrolled in those plans tend to be the younger elderly who have been retiring recently because it has been available.

Mr. CARDIN. Do you have a view as to whether prescription drug costs are increasing at approximately the same rate, greater rate or lesser rate than health care costs in this country?

Mr. LONG. Prescription drug costs under almost all third-party plans have been going up more in line with physician costs than they have with hospital costs. Hospital costs have been somewhat lower. So it is above average.

Mr. CARDIN. So the prescription drug costs are at the high end of these rising medical costs. I think your figures on table 1 are somewhat shocking.

If I understand correctly, 60 percent of our elderly do not have significant prescription drug coverage or any prescription drug coverage. For that matter, one out of four incur excess expenses in excess of $650 a year. Is that correct?

Mr. LONG. These are spending distributions ignoring the effect of insurance. These are survey data about the total spending of all elderly and disabled regardless of what insurance they might have.

So in effect, those who have drug insurance, say through private retiree health plans, should have their premium show up here and push them down into a lower per capita category.

Mr. CARDIN. So you are doing out-of-pocket expenses, including premium dollars.

Mr. LONG. No, I am total spending.

Mr. CARDIN. Suppose a retiree pays nothing for his health plan, no premium for the prescription drug component. Are you including in these the employer's charge for prescription drugs to the elderly?

Mr. LONG. If you think about it for a moment, what I have is tabulated. The set of costs each individual incurred regardless of who paid for it. That is why the skewedness.

Mr. CARDIN. For the 60 percent who have virtually no coverage at all, one out of four are paying out of pocket with no reimbursement at all, over $600?

Mr. LONG. That is correct.

Mr. CARDIN. If I understand your testimony, that amount is escalating today at three or four times the general cost of inflation.

Mr. LONG. It is going up at least 15 percent a year.

Mr. CARDIN. We have a crisis today. We will have a greater crisis tomorrow. The public is not going to let that continue. We are already hearing from our elderly. We know that cannot continue ad infinitum.

Mr. LONG. The people are concerned, the employers are concerned.

Mr. CARDIN. Employers looking to cut costs on health plans will certainly look at prescription drugs as an area to reduce costs.

Mr. LONG. Indeed.

Chairman STARK. Mr. Coyne.

Mr. COYNE. Thank you, Mr. Chairman.

In your experience with the Prescription Drug Payment Review Commission, did you examine behavioral patterns of physicians prescribing drugs once a prescription drug program was in effect?

Mr. LONG. The Commission only had two brief meetings before being repealed along with the rest of catastrophic, so as a formal commission, no. We certainly talked about what the response of physicians might be.

Our sense was in a plan with a large deductible, $600 or $650, whatever, and only a quarter of all enrollees beginning to get any benefits, or as you put it, now one-third getting any benefits, that physician's behavior in general probably would not change very much.

Our experience in studying the behavior of practitioners they may adopt a style of practice as it relates to the individual person they treat. But we are cautioned to know when physicians will take the time to code their files to know who is in what kind of insurance plan.

There would have to be some exception, say in prescribing a drug that is very expensive and a generic that is lower in price. He may ask where are you in your Medicare prescription drug coverage, have you exceeded your deductible. This is professional guessing.

I don't think that is a big cost contributor under a plan like this but that is really just a professional guess. We don't have any evidence to support that.

Mr. CARDIN [presiding]. Gentlemen, let me explain that your full testimony will be included in the committee record. You may proceed as you wish.

We will start with Mr. Gans.

STATEMENT OF JOHN A. GANS, PHARM.D., EXECUTIVE VICE PRESIDENT, AMERICAN PHARMACEUTICAL ASSOCIATION

Mr. GANS. Thank you, Mr. Chairman. I am John Gans, a pharmacist and executive vice president of the American Pharmaceutical Association, the national professional society of pharmacists.

We appreciate the opportunity to present our views on a Medicare drug benefit and H.R. 2500, your legislation providing coverage of outpatient prescription drugs for the Nation's elderly and disabled under the Medicare program.

APhA supported the drug benefit provisions of the Medicare Catastrophic Coverage Act of 1988, since repealed, and we support the principal provisions of H.R. 2500. Mr. Chairman, you were one of the leaders in securing the drug benefit provisions contained in the catastrophic legislation and made a valiant effort to retain it in the battle over repeal. We commend you for continuing to pursue the effort in this Congress. At a time when there is great potential and a clear need for an overhaul of our health care delivery system, it

would be tragic not to include pharmaceutical products and services in the debate. Your legislative proposal offers both the opportunity to correct the obvious coverage void with respect to Medicare and focus the attention of those who would seek broader reform on this critical component of health care services.

APhA's House of Delegates, the broadest based decisionmaking body in pharmacy, has called for Medicare coverage of outpatient drugs for nearly a quarter of a century. In 1968 our House of Delegates adopted a policy which said,

> The Committee does not think it is reasonable to deny those receiving Social Security benefits the essential item of pharmaceutical services so necessary to complete therapy and health care benefits in this modern society.

In 1987, our House of Delegates specifically supported inclusion of an outpatient drug benefit as part of catastrophic illness coverage.

Mr. Chairman, as you well know, pharmacy services are becoming an increasingly important and essential part of health care delivery in terms of both improving the health status of patients and assuring cost savings by eliminating, reducing or forestalling the need for expensive inpatient diagnostic and therapeutic services.

In November 1990, after a year of self-study which included input from over 2,000 of the Nation's pharmacists, APhA approved as the mission of pharmacy, "To serve society as the profession responsible for the appropriate use of medications to achieve optimal therapeutic outcomes." The pharmacist of today is extraordinarily well-educated and trained to be on the front line of providing care to our Nation's citizens. In addition to their skills in filling prescription orders and product selection, pharmacists play the pivotal role in the drug use evaluation process. This process involves an evaluation of the patient's medical records for drug-related problems, therapeutic duplications, significant drug interactions and inappropriate or unnecessary therapy. We need to provide the environment in which the pharmacist can use these professional skills. We certainly believe Medicare would provide more cost-effective health care coverage by making these skills available to its beneficiaries in the outpatient setting. To the extent that it has not and does not cover such pharmaceutical care, Medicare has been extraordinarily shortsighted in terms of its failure to promote health care and cost savings.

Comprehensive pharmaceutical services are important for all patients but are even more critical for the Nation's elderly who, according to several recent studies, take as many as 15 to 18 medications routinely, including prescription and over-the-counter drugs. Problems related to compliance, adverse reactions and interaction are more acute in the elderly population than in the general population. One recent study found that just under one in four hospital admissions of those patients over 65 was the result of one type or another drug misadventure. Clearly, the elderly have the greatest need for aggressive monitoring and counseling in the use of medications.

One of the most important results of the debate on the Medicare catastrophic legislation was that it raised the consciousness of policymakers to these problems and acknowledged the role pharmacists could undertake to correct them. A Medicare drug benefit con-

tinues to be the highest health care priority for our Nation's seniors; not surprising since prescription drugs represent the largest out-of-pocket expense for approximately 75 percent of the elderly.

Mr. Chairman, your proposal contains many of the same provisions found in the Medicare Catastrophic Coverage Act of 1988. Before addressing the specifics, I want to make two general remarks. The first is that we are in a more advantageous position to comment on the provisions today because between the time of passage and repeal of the catastrophic legislation, the Health Care Financing Administration issued a number of proposed regulations interpreting statutory language. Quite frankly, while we thought we understood congressional intent and were generally satisfied with the statute, HCFA's creativity astounded and dismayed us almost to the point of advocating repeal. That lesson should not be lost, so we call upon you and other Members of Congress to be as specific and directive as possible to prevent undermining of your intent.

Second, Congress made several significant changes in the Medicaid drug benefit as part of the Omnibus Reconciliation Act of 1990. Many of those changes had their genesis in the catastrophic legislation and were strongly supported by APhA. It is important that a Medicare drug benefit work in concert with the Medicaid provisions of OBRA 1990.

Because of their experience with third-party payer programs, pharmacists' greatest concerns regarding expansion of Medicare to cover outpatient drugs relate to reimbursement. The fear is that Medicare would be another third-party program that would use market leverage to force participation of pharmacies on a loss basis. It is critically important that the drug benefits' payment mechanism be structured to provide fair, incentive-based reimbursement that will maximize pharmacist participation and thus assure access by beneficiaries to appropriate products and services.

It is also important that Congress understand how pharmacists have been caught in the middle of forces that are not within their control and which have made the question of survival an everyday reality. On the one hand, manufacturers' prices have been escalating at an extraordinary rate over the past decade, a fact well documented over the past several years in congressional hearings and again in a June 1990, HCFA study entitled "Manufacturers' Prices and Pharmacists Charges for Prescription Drugs Used by the Elderly." These increases have especially hurt the community pharmacist who has not received the deep discounts most manufacturers make available to institutional and prepaid health plans. At the same time, cost containment efforts by third-party programs, including Medicaid, have focused on restricting pharmacy reimbursement since these programs found they could not prevent manufacturers' price increases. Pharmacists have been forced to shift losses from third-party coverage to the fee-for-service market, but with that market shrinking rapidly, pharmacy gross margins have been slashed to a precariously low level. If Medicare were to fail to address this problem, the results would indeed be catastrophic for pharmacy as the Medicare population is simply too large a share of the market for which losses could possibly be absorbed.

A reasonable interpretation of the language of H.R. 2500 regarding payment amount is that it does provide adequate reimbursement for pharmacists. But similar language contained in the Medicare catastrophic legislation was manipulated by HCFA in a way that independent experts concluded would have resulted in reimbursement at about a $2 loss per prescription. I cannot emphasize strongly enough what an adverse effect the drug benefit would have on pharmacy unless the language is further refined to preclude a similar situation from occurring. Further, continued vigilance as to regulatory action by HCFA would, in our view, be necessary.

We also believe the bill's reimbursement system would be more effective, as well as consistent with existing third-party payment procedures, if the surveys of prices called for in the bill were monthly rather than biannually and payment of claims to pharmacists were made more frequently than on a monthly basis. A biannual survey is patently unfair as it would mean that reimbursement would be based on year-old costs, and as Congress now knows, manufacturers' prices for drugs undergo substantial increases during any give year. Indeed, sometimes prices for a specific drug increase more than once a year. Computer software is readily available to conduct surveys on a monthly basis.

Once a month payment of claims is also unfair. Virtually all third-party plan administrators now pay more frequently that monthly—usually on a 2-week cycle or less.

One other reimbursement provision in H.R. 2500 which requires modification. The provision relates to restrictive prescriptions issued by telephone and the requirement that the physician or other prescriber submit subsequent written confirmation. It would be unfair to punish the pharmacist by denying reimbursement when a physician fails to comply with the requirement for written confirmation. We urge you to assure payment to the pharmacist upon demonstration that a good faith effort to secure the followup confirmation from the prescriber has been made.

One of the most important concepts contained in the catastrophic legislation was to promote involvement of pharmacists in patient medication reviews and counseling and to establish standards for appropriate drug use against which prescribing and dispensing practices could be evaluated. We strongly supported this concept and were pleased to see it incorporated in the OBRA 1990 Medicaid amendments. Your legislation includes provisions relating to patient counseling and assuring appropriate prescribing and dispensing practices. We encourage you to review the approach taken in OBRA 1990 with Medicaid and make minor modifications to H.R. 2500 which would make DUR in Medicare and Medicaid consistent with and complementary of each other. We believe the more detailed language in OBRA 1990 offers more guidance and assured more effective implementation of prospective and retrospective DUR.

We are pleased that H.R. 2500 calls for providing point-of-sale electronic claims processing equipment for pharmacies. We assume it is not the intent of H.R. 2500 to require prospective DUR as part of the electronic claims processing system. While we agree an electronic claims system offers great potential for concurrent or pro-

spective DUR, we believe the approach taken in the OBRA 1990 Medicaid provisions of a multi-State demonstration project on the feasibility of linking prospective DUR with the electronic claims systems is essential.

We strongly support provisions in H.R. 2500 reestablishing the Prescription Drug Payment Review Commission as an independent panel with responsibility for gathering information on drug prices and utilization and making recommendations on payment methodologies.

We were surprised to see H.R. 2500 include a provision for a study of mail order pharmacy similar to the one included in the catastrophic legislation since such a study—entitled "Study to Evaluate the Use of Mail Service Pharmacies"—was undertaken and completed for HCFA in 1989. I would note for the subcommittee that the study found that the cost of mail order was essentially the same as community pharmacy services. For effective counseling and monitoring to occur, a personal relationship between the patient and their pharmacist must exist. That relationship and the availability to provide emergency prescription drug care needs to the community clearly demonstrates the superior value of community pharmacy over the mail order pharmacy.

With respect to the studies to be conducted by the General Accounting Office on the costs of drugs and pharmacy operations, we would recommend that there be a single study. This study should look at the areas described as well as discriminatory pricing practices of manufacturers and the value of the cognitive services provided by the pharmacists. The objective of such a single study should be to explore the feasibility of alternatives to the existing system of reimbursement for pharmacy services.

Mr. Chairman, we have not had the opportunity to analyze in detail all technical aspects of H.R. 2500 and request permission to submit additional comments for the record within the next 2 weeks.

Finally, I want to thank you and the subcommittee for offering us the opportunity to present the views of the American Pharmaceutical Association. We look forward to working with the Members and staff in further development and advancement of the much-needed bill.

Chairman STARK. Without objection we would welcome those comments.

Mr. Rector

STATEMENT OF JOHN M. RECTOR, VICE PRESIDENT OF GOVERNMENT AFFAIRS AND GENERAL COUNSEL, NATIONAL ASSOCIATION OF RETAIL DRUGGISTS

Mr. RECTOR. Knowing my statement will be printed in the record, I will attempt to highlight what we view to be the more salient points on today's subject.

I wish we had kept the thousands of copies of the guide that we did on the 1988 act and its prescription drug coverage that the Merck Corp. was so kind to help us with which we distributed to every pharmacy in the country.

I would suggest a review of that document and perhaps consideration that it appear at the appropriate point in the record.

As you know we supported the House bill in 1987. We were part of a coalition that strongly supported it, long before the final provisions that were negotiated were signed by President Reagan. We were concerned and disappointed by its repeal.

On the other hand, we have at least the same level of reluctance about this subject as we did in 1987 and not to belabor those concerns but we had an extraordinarily horrible problem with the Medicaid prescription drug program and we think that H.R. 2500 goes a long way to address that. We urge you to consider several of the key provisions in the bipartisan legislation introduced in the Senate last year by Senator Pryor, Trent Lott, and others. It was S. 2605. In light of some earlier comments today I wanted to focus on the whole business of pricing which seems to intrigue so many.

In your quest for source for funding we may have a notion that is a little different. We heard about the 12 EC countries that have special pricing in Mexico and Canada. The fact is that most of the Medicare and Medicaid entities are purchasing prescription drugs under very favored pricing. I think the heart of the problem is neither Medicare nor Medicaid are experiencing the fiscal benefits of pricing available to hospitals, HMOs, clinics, and the like.

We recommend that you take a long hard look at that. As you know there is rampant price discrimination in our market. As was mentioned a minute ago, there are parallels between Canada and United States markets in terms of drug distribution. I can tell you one parallel there is not. We are denied by industry in our buying groups prices based even on economies of scale. We could put every independent drugstore in the United States together and not get a better price than a 12-bed, not-for-profit hospital. It is one of those subjects we have struggled with.

We suggest that you look at a multitier reimbursement formula. Hospitals and other outfits are not paying what a retail pharmacy is paying. You look at the acquisition costs, overhead and services and pay them accordingly. They are buying at one-fourth to one-fifth of our costs. I think you will see the scope of available savings. Contrast this with how much Medicare is presently paying for the prescription drug coverage. I can remember when Energy and Commerce considered what became the Prescription Drug Marketing Act, many days of hearings and a long investigation, it appeared in 1986 and 1987, in that period, that the hospitals and others are billing three to five times retail. Medicare is absorbing extraordinary expenses for prescription drugs far more than Medicaid outpatient pays retailers in our marketplace which is the highest retail price.

I have some specific prices I wanted to make reference to briefly. There has been a rather disgusting debate in recent months about David Pryor's efforts that led to OBRA provisions along with Ron Wyden, Jim Cooper, and others in the House. There has been unhealthy speculation about what has happened to the pricing on prescription drugs for HMOs and hospitals and the like.

If they have had a 5 to 8 percent increase we have had a similar one. What we encourage you to look at is what is the spread. We got a recent price sheet from a nonprofit in Michigan. The spread is larger now than it was 5 years ago. So don't get distracted on

whether they had a 5 or 6 percent increase. Look at the fact that they are paying 85 percent less for coumadin this year than we are. You would have to have a 700 percent increase on their part to match the circumstance that we are in.

We recommend that you take a long and hard look at that. And we recommend you look at the Wisconsin statute that prohibits access to groups buying prescription drugs.

We are encouraged by the electronic system and hope it affects the payment of claims.

We think conserving consumer choice is very important.

We think that if a mail order pharmacy has access to the program that they should have it on the same terms of professional regulation as our members who would provide most of the Medicare prescriptions.

Thank you very much for the opportunity to make brief comments on a very important piece of legislation.

Chairman STARK. Thank you, Mr. Rector.

[The prepared statement and attachments follow. Additional attachments are being retained in the committee files:]

STATEMENT OF JOHN M. RECTOR

BEFORE THE HOUSE WAYS & MEANS COMMITTEE

HEALTH SUBCOMMITTEE

JUNE 11, 1991

Mr. Chairman, Members of the Subcommittee:*

I am John M. Rector. I serve as Vice President of Government Affairs and General Counsel for the National Association of Retail Druggists.

The National Association of Retail Druggists (NARD) represents more than 39,000 independent pharmacies, where over 75,000 pharmacists dispense more than 70% of the nation's prescription drugs and related services. Independent pharmacists serve 18 million persons daily and provide 85% of the Medicaid pharmaceutical services. More than 60% of our members are currently involved in providing home health care. NARD has long been acknowledged as the sole advocate for this vital component of the free enterprise system. We are the only national pharmacy association with universal state association membership, including those of the Subcommittee's members.

NARD members are primarily family businesses. They have roots in America's communities. The neighborhood independent druggist typifies the reliability, stability, yet adventuresomeness, that has made our country great.

Competition amongst retail pharmacies is alive and well. Competition is an incentive for efficiency and the price competition in retail pharmacy is greater than can be found among the other providers of health services. On the average, our members obtain a 3% pre-tax net profit.

As owners, managers and employees of independent pharmacies, our members are committed to legislative and regulatory initiatives designed to protect the public and to provide them level playing field and a fair chance to compete. We appreciate the opportunity to appear before the Subcommittee to assist in the assessment of H.R. 2500, the Medicare Prescription Drug Act of 1991, introduced on May 30, 1991.

We believe that a major strength of the health care system is the thousands of independent community pharmacies readily accessible to virtually every segment of the population. Any revisions in the Medicare program should capitalize on the strengths of the existing retail distribution network for drugs, and related products and pharmacist services.

We approach the subject of today's hearing with considered reluctance. Not because we oppose the concept, in fact we support it. Our statement of positions addresses it as follows:

> "NARD supports the position that any national health insurance program adopted by the Congress include outpatient medications as an integral part of its benefits. Patients participating in these programs also must be ensured that they will have the right to select the pharmacist and pharmacy of their choice to obtain their prescription drugs. Pharmacies providing

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*Fortney H. (Pete) Stark, (D-Calif.), Chairman
MAJORITY: (7-D) Fortney H. (Pete) Stark (Calif.), Marty Russo, (Ill.), Brian Donnelly (Mass.), William J. Coyne (Penn.), Sander M. Levin (Mich.), Jim Moody (Wisc.), Benjamin L. Cardin (MD).
MINORITY: (4-R), Willis D. Gradison, Jr. (Ohio), Rod Chandler (Wash.), Nancy L. Johnson (Conn.), Raymond J. McGrath (NY).

prescription medications should be compensated on the basis of the market- place price for such products and services. Independent retail pharmacists should be assured a key role in the planning and development of any such drug program."

One source of our caution is the less than favorable experience that our members have had from the outset with the non-statutory Medicaid prescription drug program, and in recent years with the home health components of the Medicare program. We are concerned that a Medicare outpatient drug benefit program not replicate unsatisfactory aspects of the Medicaid prescription drug program. Likewise, with more than 60% of our members involved with Medicare home health, it is critical that an outpatient drug coverage benefit be designed in a manner that will avoid the scandalous failure of Medicare to pay its participating providers in a timely, business-like manner; avoid the constant barrage of arbitrary and inconsistent regulations; and, address captive referral and other conflicts of interest.

I hasten to add that the landmark Medicaid Price Discrimination and Patient Benefit Restoration Act (MADPA) recently enacted as part of OBRA 90 has satisfactorily addressed many of our independent pharmacy's concerns about the Medicaid program. We strongly support consumer and Medicaid recipients' efforts for this legislation that provides the Medicaid outpatient drug program equal access to manufacturer drug prices now available to Medicaid generally and to other nonprofit entities and other MADPA reforms. We are pleased with the enactment of the NARD moratorium. I hasten to add that many members of the subcommittee have supported the NARD moratorium and rebate or "lower of" concepts since we proposed them to the subcommittee in early 1985.

Another source of our caution was the devastating regulatory proposals from the Bush Administration in the fall of 1989, ostensibly to implement the prescription drug component of the 1987 Act. As a consequence of these totally unacceptable proposals, independent pharmacists from across the country unanimously approved the following Resolution at our House of Delegates in San Antonio, Texas, November 1989:

RESOLUTION #3

PARTICIPATION IN FEDERAL PROGRAMS

WHEREAS, most creditable surveys indicated that independent pharmacy was, understandably, very skeptical about participating in another federal outpatient drug program; and

WHEREAS, merely a bare majority of independent pharmacists supported an outpatient drug benefit under Medicare, whatever the terms; and

WHEREAS, legislation similar to the recently repealed Medicare prescription drug benefit could be considered by Congress in the future; and

WHEREAS, the Inspector General of the U.S. Department of Health and Human Services (HHS) and other high ranking Federal officials, including the Health Care Financing Administration (HCFA),1 repeatedly stressed that a high percentage of retail pharmacy participation (e.g., 90%) would be essential for the program to succeed; and

WHEREAS, retail pharmacy has had a very unfavorable experience with HCFA's management of the non-statutory Medicaid program, especially HCFA's 1984-89 campaign to force states to confiscate earned discounts; and

WHEREAS, HCFA officials have repeatedly told the National Association of Retail Druggists that, so long as retail pharmacy participated in a nearly universal way, complaints about the Medicaid or Medicare programs would always go unheeded; and

WHEREAS, HCFA opposed fair terms of reimbursement for retail pharmacy in the Medicare legislation and then after its enactment attempted to totally undermine, by proposed regulations, the terms of pharmacy payment in the Medicare law;

BE IT RESOLVED that NARD respond to the HHS/HCFA concern about the likely level of participation by retail pharmacy in any future Medicare program by predicting that few independent pharmacies would make individual judgments to participate in a Medicare programm with the terms that the Bush Administration proposed via HHS Secretary Sullivan's September 7-8, 1989, regulations; and

BE IT FURTHER RESOLVED that before Congress enacts a similar benefit, that NARD inform Congress that independent retail pharmacy will oppose it unless all essential terms of pharmacy payment are fair and unmistakably stated in the law in a manner that will prevent the Administration and HHS/HCFA from diluting the terms of pharmacy payment.

Also related to our consideration of H.R. 2500 is the NARD 1986 House of Delegates resolution calling for the establishment by law of the Medicaid prescription drug program reforms it has been advocating for more than a decade. Its full text is as follows:

WHEREAS, Congress never intended that the normal business practices of retail pharmacy such as earned discounts or marketplace pricing be placed in jeopardy, such as under MAC, EAC, PhIP and CIP, when a pharmacist serves patients in the Medicaid program; and

WHEREAS, the concept of a government discount, whether in the form of a discount off ingredient cost or a total charge, is totally unacceptable;

BE IT RESOLVED that NARD continue to oppose the concepts of a discount and instead, together with a coalition of pharmacy practitioners, wholesalers, manufacturers, physicians and consumers support the establishment by law of: (1) marketplace pricing at the 90th percentile (MAPP), and (2) a direct payment voucher system to reduce Medicaid administrative costs and assure prompt payment.

The two core themes of suggested reform; marketplace pricing and a direct payment system to reduce administrative costs and help assure that prompt payments are universally supported within the industry. In fact, National Association of Chain Drug Stores, Pharmaceutical Manufacturers Association, American Society of Hospital Pharmacists, American Pharmaceutical Association, National Wholesale Druggists Association, American Society for Consultant Pharmacists, and NARD all endorsed a document, "Principles for Reform of Medicaid Payment for Outpatient Drugs" in correspondence to then HCFA Administrator Roper on May 26, 1986.

In 1987 we supported the House legislation which was very similar to H.R. 2500. These principles were helpful to our assessment then and the principles, in our view, are equally applicable to the subject of today's hearing. Unfortunately, the Administration has not embraced them. We have provided the subcommittee with extensive information on these core ideas, including the NARD/Pracon study Marketplace Economics -- Alternatives in Medicaid Prescription Reimbursement (Oct. 1986). The full text of the "principles" follows:

PRINCIPLES FOR FEDERAL REFORM OF PAYMENT
FOR OUTPATIENT DRUGS

Following the implementation of the Medicaid program in 1965, pharmacists, more than other provider groups, enthusiastically supported and participated in this important health care program for the needy. Ten years later, in 1975, the Federal government adopted the Maximum Allowable Cost/Estimated Acquisition

program. This controversial approach established a complex set of formulas that imposed artificial controls on the retail marketplace and interfered with professional judgments regarding the selection of prescription drug products provided to the poor. In more recent years, the Medicaid program has been moving toward a reimbursement scheme that would further reduce reimbursement to pharmacies.

The Federal government seems content to capture limited, short-run savings at the expense of retail pharmacy providers and the research-intensive pharmaceutical manufacturing industry, while ignoring significant opportunities for reducing health care costs by allowing the competitive marketplace to function efficiently and effectively. In response, many prominent national organizations representing all components of the nation's drug distribution system -- pharmaceutical manufacturers, drug wholesalers, independent pharmacies, chain drug stores, hospitals and the pharmacy profession -- have been advocating a complete overhaul of the Medicaid drug reimbursement system. These organizations are calling for less government intrusion so that the nation's pharmacies can continue to provide the highest standard of care and service to needy people.

FUNDAMENTAL PRINCIPLES

Reduce needless federal regulation. American society experienced a virtual explosion in Federal Government regulation during the past decade. Between 1970 and 1979 the number of pages published annually in the Federal Register nearly tripled and the number of pages in the Code of Federal Regulations increased by over two-thirds. The current Medicaid drug program was part of this growth.

Although well-intended when originally developed, the Medicaid drug program has failed to keep pace with rapid changes in health care delivery over the past ten years. This has resulted in pharmacy providers subsidizing the Medicaid program because they frequently lose money when they fill a Medicaid prescription. Moreover, the hardship and uncertainty imposed on business by this over-regulation has impeded business decisions and expansion plans, ultimately reducing economic growth and the creation of jobs in the private sector. This over-regulation is particularly burdensome to small and independent businessmen and women, such as pharmacists who are proprietors of community pharmacies, and causes them to defer or terminate plans for expansion.

Our position on Medicaid drug reimbursement is directed at minimizing governmental intrusion by reforming or eliminating regulations which are unnecessary and counterproductive.

Improve administrative practices. Approximately 171 million claims are processed each year by the Medicaid program. Wasteful administrative overhead consumes resources that should be targeted on the health needs of beneficiaries. Furthermore, current inefficient administrative practices impose needless hardship on retail pharmacies due to slow and erratic payment and excessive paperwork. Initiatives to improve administrative practices can reduce both public and private costs to process Medicaid claims, and insure timely payment to pharmacies.

Rely on the marketplace. We do not need excessive Federal regulation to solve the problems of Medicaid

drug costs. As long as we let the forces of the marketplace work without undue interference, the ingenuity of consumers, businesses, producers and inventors will do that for us. The retail drug market is dominated by self-pay customers who, along with increasingly cost-conscious third party payers, impose competitive discipline on marketplace prices. If we allow it to, the magic of the marketplace will unleash new competition, giving the Medicaid program lower prices, and Medicaid beneficiaries more choices and better services.

To achieve more meaningful reform, public policies governing the Medicaid drug program should be revised along the following lines:

- Base drug reimbursement on sound economic principles through the elimination of artificial controls. This would be achieved by replacing the current provisions governing reimbursement with marketplace pricing, i.e., usual and customary charges for all products and services, capped, for example, at the 90th percentile for all charges within a state.

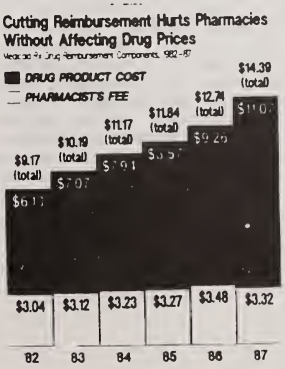
- Implement a new and streamlined reimbursement mechanism that would greatly lower administrative expenses in the program. Such a worthwhile objective can be easily accomplished by coupling marketplace pricing with an innovative system of drug vouchers.

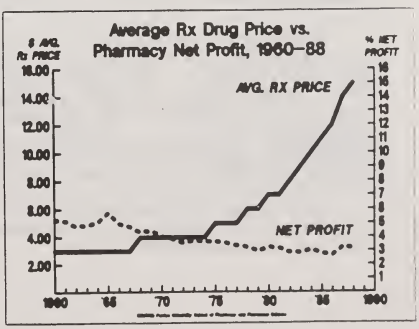
States shall build upon this basic set of principles established by the Federal Government, tailoring their individual programs to fit local circumstances.

INITIAL COMMENTS ON MEDICARE PRESCRIPTION DRUG BENEFIT ACT OF 1991

We have attempted to assess the legislation as expeditiously as possible. We do expect to file more detailed comments with the subcommittee and its staff. We support appropriate outpatient prescription drug coverage under Medicare.

We cannot stress too much, however, our very real concerns that the shortfalls and disasters for providers, especially under the non-statutory laissez-faire Medicaid program, not taint the opportunity which the subcommittee has to address the drug needs of the elderly. The following charts from the August 1989 report of the U.S. Senate Special Committee on Aging "Prescription Drug Prices: Are We Getting Our Money's Worth?" (pp. 38-39) effectively demonstrate one of the major problems our members have experienced under the Medicaid Prescription Drug Program:





Much progress has been made towards the enactment of marketplace pricing (MAPP) reimbursement for retail pharmacists participating in the Medicaid outpatient prescription drug program. This concept developed by our organization was formally submitted to HHS in 1983 and has been endorsed since 1986 even by the Pharmaceutical Manufacturers Association. Had the Medicare Catastrophic program not been repealed, it could have been the reimbursement standard. And of course, MAPP was included in the bipartisan "Pharmaceutical Access and Prudent Purchasing Act of 1990." S.2605, PAPPA, last year. Major consumer groups supported this approach including NCSS, AARP, Families USA, NARFE, AAHA and others.

Now that MADPA has focused HCFA on the source of prescription drug price increases, the moratorium period should be more than adequate to enact this fair reimbursement formula. The MAPP approach reimburses the pharmacists as any other small business person would be reimbursed, but also provides payment for professional services. In effect, it is payment for a "pharmacy visit" somewhat like an office visit for a physician. Of course, there are appropriate screens, including the "lower of" provisions which will continue to provide Medicaid the benefits of our very competitive retail marketplace.

We recommend that the subcommittee adopt the MAPP reimbursement for the outpatient Medicare program in lieu of that provided by H.R. 2500.

As the subcommittee is thoroughly aware, price discrimination permeates the prescription drug marketplace. To maintain such discriminatory prices, even our independent buying groups are denied equal access to prices based on economies of scale.

As a witness at your opening hearing on the recently repealed Medicare Drug Benefit Act, held April 22, 1987, I can vividly recall an observation of the witness for the National Council of Senior Citizens who urged Congress to determine how it is that a prescription drug costs one consumer $18.25 and the same drug costs another consumer $0.73?

These practices continue today, yet neither Medicare nor Medicaid currently benefits from the price discrimination in our market. For example, last month in a Kansas City investigation by a federal grand jury, it was alleged through indictments that members of a so-called "organized crime" family purchased prescription drugs at the discriminatory nursing home price, involving reductions as much as 90% off the acquisition price. While such alleged criminals enrich themselves through resale of the products, neither Medicare nor Medicaid enjoys the benefits of such pricing when the products are used legitimately. (See enclosed Kansas City Star, May 11, 1991, page 1, for article entitled "KC mob boss, 4 associates are indicted . . . Anthony Civilla linked to plan to divert drugs meant for nursing homes, by John T. Dauner and Joe Stephens.)

If Medicare generally had access to the savings associated with such prices, perhaps this "windfall" revenue could finance the non-copayment costs of a Medicare outpatient prescription drug program with the characteristics of H.R. 2500.

Perhaps this could be accomplished through the establishment of multi-tier reimbursement programs to parallel the multi-tier pricing levels. Hospitals, nursing homes, HMO's and others would each have an AWP reflecting in part their actual acquisition costs. Or, in the alternative, these purchasers could be required to provide rebates to Medicare based on standards similar to "best price" and "average marketplace price" or AMP, of the MADPA law.

We recommend that you include a provision that would limit physician dispensing to rare rural remote circumstances when it can be demonstrated that a pharmacy is not available.

Prescription drug samples which were retained by a very narrow margin under the provisions of the Prescrition Drug Marketing Act are available for any true emergency when a 24-hour pharmacy emergency number, which is common, is not available.

We support co-payment. It should be mandatory. Nearly 70% of the practice of typical independent pharmacists involves prescription drugs and 10-15% of our members provide only prescription drugs. They rarely "loss lead" prescription drugs and would be placed at a decided competitive disadvantage if the copay is not mandatory.

We believe that pharmacy practitioners should have significant representation on the Prescription Drug Payment Review Commission.

We encourage the application of the electronic system to both the adjudication of claims, as well as the payment of claims.

Mail order pharmacies also receive discriminatory prices when they purchase prescription drugs. Such pharmacies and their out-of-state, unregulated pharmacists were determined by Congress to be ineligible as a participating pharmacy under recently repealed Medicare Catastrophic Act. This is the safest approach for Medicare beneficiaries

We ask the subcommittee to note that increasingly, patients being treated for chronic illnesses are being misled into believing that the so-called "maintenance medications" they are taking are risk-free, that they do not require regular monitoring by their local pharmacists.

Mail order pharmacy promotes this notion that patients on long-term prescription drug treatments for hypertension, heart disease, diabetes and other chronic ailments do not require face-to-face counseling and regular follow-up by a pharmacist. This is a serioius misconception that exposes many patients to unnecessary health risks.

We believe, with the consumer groups, that it is paramount to protect consumer choice of pharmacy and pharmacist. Current Medicare law and H.R. 2500 concur. However, as the debate about national health insurance and other alternatives designed to provide uninsured coverage proceed, we think that it is important to renew a commitment to consumer choice which is the hallmark of our very competitive retail marketplace.

We strongly support pro-competitive, pro-consumer pharmacy choice legislation such as S.235, recently signed by the Honorable Bill Clinton, Governor of Arkansas, which became effective on April 1, 1991. It provides consumers equal access to competing pharmacies and equal access for pharmacists to insurance contracts providing prescription coverage for consumers. It does not mandate coverage of prescription drugs; and, importantly, it does not alter any cost containment features of a contract.

I should note that the Health Insurance Association of America, numerous insurance companies, Baxter Laboratories, and Medco Cost Containment, Inc., among others, have repeatedly failed in their effort to stifle enactment of this pro-competitive, pro-consumer legislation. Fortunately, their anti-consumer, anti-competitive (e.g., price fixing, tying agreements, etc.) prescription drug proposals have been rejected at the state level and should be rejected by Congress.

If mail order pharmacists are permitted access to Medicare, for example, as an employee of a non-participating pharmacy, it is very important to assure that any pharmacist providing

assistance to Medicare beneficiaries is subjected to the laws and regulations of the beneficiaries' state. All professions are regulated in this manner.

Presently, laws regulating the private sector reach only the out-of-state entity, the pharmacy, and then only at a very minimal level. In fact, consumers are far more substantially protected from the consequences of an out-of-state truck than they are an out-of-state pharmacy. An out-of-state pharmacist is totally unregulated, thus leaving consumers in-state unprotected. Consumers of prescription drugs are entitled to equal protection. Our concern and those of the consumer groups are brought even more clearly into focus when one suggests that equal protection could mean that the laws and regulations should apply to no pharmacists. We believe that they should apply to all, especially pharmacists at the lowest denominator via the mail.

We recommend that the study to be conducted by HHS on the potential use of mail order pharmacists be deleted. In fact, this study was conducted by Brandeis University and the University of Maryland and was completed and submitted to HCFA in the fall of 1989. Interestingly, even in the instance of so-called maintenance medications, this study determined only a 2-cent net difference between the cost of a prescription from a traditional full-service pharmacist and a prescription provided by unregulated out-of-state mail order pharmacist with access to prices substantially below the best price available to other retail pharmacists.

Under H.R. 2500, the GAO is required to conduct a study "of the discounts given by pharmacies to other third-party insurers." Those who are familiar with the impact of the insurance industry antitrust exemption know that to characterize the reimbursement for pharmacists fixed by the insurance industry and intermediaries in "take-it-or-leave- it" contracts as voluntary on the part of the pharmacists is similar to characterizing the victim of an armed robbery as having donated cash to the assailant's favorite charity. It is our view that once H.R. 9, the Insurance Competitive Pricing Act, authored by House Judiciary Committee Chairman, Jack Brooks, is enacted, the notion of "given" will have a more traditional meaning. Thus, we recommend that this study be deleted, or in the alternative, that it be reformulated to reflect the realities of our third-party prescription drug marketplace.

CONCLUSION

As mentioned, it is our intent to submit additional comments once we have more thoroughly assessed H.R. 2500. We look forward to assisting the subcommittee and its staff in the refinement of this legislation.

On behalf of the Officers, Executive Committee, and members of the National Association of Retail Druggists, we thank you for the opportunity to appear and continue to participate in the formulation of Medicare Part B outpatient prescription drug coverage.

COALITION
ON

RE: PRESCRIPTION DRUG BENEFIT UNDER MEDICARE CATASTROPHIC PLAN

July 15, 1987

U.S. House of Representatives
Washington, DC 20515

Dear Member:

The undersigned organizations are writing to you regarding the Medicare catastrophic bill (H.R. 2470) which is coming before the House for consideration next week.

We are especially concerned that the Medicare outpatient prescription drug benefit contained in the bill remain intact. We urge you to vote against any amendment to strike or weaken this provision. The existing provision encourages the use of generic drugs. An amendment, if offered, would undermine vital cost-saving features of the prescription drug benefit without justification.

Under H.R. 2470, physicians who wish to authorize reimbursement for a more expensive brand drug can do so by indicating in their own handwriting when a brand name drug is medically necessary. This is a simple mechanism which permits a physician to exercise his or her own medical judgment. Certain pharmaceutical companies may seek a change in this provision to allow payment for expensive brand name products in the absence of such specific medical judgments.

Senior citizens, who will be paying for this Medicare prescription drug benefit through increased premiums and a 20 percent direct share, need the reasonable reimbursement approach offered in H.R. 2470.

By permitting weaker procedures to govern the Federal reimbursements, the loss of generic savings would be substantial. In many states, such casual instructions as simply checking a box can preclude generic dispensing even

when the patient's medical and economic interests are consistent with the use of the generic.

The payment rule contained in H.R. 2470 is an appropriate and necessary way to control costs and should remain intact.

Sincerely,

American Association of Retired Persons
National Council of Senior Citizens
Consumer Federation of America
Consumers Union
National Consumers League
Public Voice for Food and Health
Generic Pharmaceutical Industry Association
National Association of Pharmaceutical Manufacturers
United Auto Workers
United Food and Commercial Workers International Union
International Ladies Garment Workers Union
American Federation of Teachers
Service Employees International Union
United Steelworkers of America
AFSCME
National Association of Retail Druggists
National Association of Chain Drug Stores

Kansas City STAR 5-11-91 p. 1

CITY STAR

EDITION 50c

KC mob boss, 4 associates are indicted

Anthony Civella linked to plan to divert drugs meant for nursing homes.

By JOHN T. DAUNER and JOE STEPHENS
Staff Writers

Kansas City mob boss Anthony "Tony Ripe" Civella and four associates diverted more than $1 million in drugs intended for nursing homes to an illicit "gray market," a federal grand jury charged Friday.

The men allegedly set up four pharmacies to defraud manufacturers by buying prescription drugs meant for nursing homes — at discounts of perhaps as much as 90 percent. They resold the drugs at higher prices to wholesale drug firms in California and Nevada, authorities said.

The diversions allowed the pharmacies to obtain drugs at artificially low prices, authorities said. The alleged scheme also made it difficult to track the flow of drugs and ensure their safety.

"When the gray market gets hold of them, we don't know how they are stored," said Wilson Winch, the Missouri pharmacy inspector who uncovered the operation. "We don't know how they are shipped; we don't know how they are handled. It could be unsanitary and dangerous."

The drugs ended up at individual pharmacies.

The indictment means more trouble for the Civella, 61, who was released from prison in January 1988 after serving more than three years for racketeering and bookmaking. Once on the streets, authorities believe Civella quickly claimed the mob throne in

See **MOB, A-13,** Col. 1

Mob boss, associates accused of defrauding drug companies

Continued from A-1

Kansas City, an honor formerly held by his father, Carl Civella, and uncle, Nick Civella.

Also named in the 19-count indictment released Friday:

- Donald V. Costanzo, 53, a Gladstone nursing home owner.
- Scott A. Clawson, 29, a former Kansas City pharmacist who now lives in Las Vegas.
- Carl A. Artese, 71, involved in a bankrupt Kansas City area heating and air-conditioning firm.
- Martin Rubin, 40, of Thousand Oaks, Calif., a pharmaceutical wholesaler.

The indictment also named John Sansone, Civella's late son-in-law, as an additional conspirator.

The men ran the scheme from January 1987 to October 1989 and diverted more than $1 million in prescription drugs, according to the indictment.

In general, they are believed to have told manufacturers they were buying the drugs for resale to local nursing homes to obtain special discounts, Winch said. About once a week, the pharmacies reshipped a dozen or so boxes of the drugs to the wholesalers, who sold them to stores at much higher prices, he said.

Drugs that disappear from official records and are secretly resold make up a "gray market" of unknown size across the country, officials said.

Winch alerted the FBI after he stumbled across "dramatic shortages" of drugs while conducting a routine audit at Penn Park Pharmacy Inc., 2950 Kendallwood Parkway in Gladstone. The pharmacy later was renamed Institutional Pharmaceutical Services Inc.

"When you go into a pharmacy and they've been ordering thousands of something and they don't have any of it on the shelf," he said, "you think, 'Gosh, where did it go?' "

Federal and Kansas investigators traced the alleged scheme to three other firms: Kendallwood Pharmaceutical Supply of 8405 N. Cosada Terrace; Care Pharmacy of 8686 W. 96th St. in Overland Park; and Penn Park Institutional Pharmacy in Topeka. All the pharmacies are closed.

"They never even stocked these two places" in Kansas, said Tom Hitchcock, the executive secretary of the Kansas Board of Pharmacy. "They obviously weren't ready to open, but they had a pharmacy permit."

Hitchcock said visiting inspectors were told repeatedly: The store will open next week.

"It's a crazy deal," he said.

The indictment charges that the discounted drugs were resold to D.W. Wholesale of Van Nuys, Calif., and B.W. Wholesale of Las Vegas. Rubin owned the Las Vegas wholesaler and owned part of the California company, the indictment said.

The three Kansas City area defendants were arrested by the FBI Friday.

Civella's bond was set at $50,000, Costanzo's at $25,000 and Artese's at $10,000. They were released on the the signatures of family members.

Clawson was arrested by the FBI in Las Vegas.

Anthony Civella, known as "Tony Ripe," is the son of Carl "Cork" Civella, who was convicted in the early 1980s of skimming Las Vegas gambling receipts, racketeering and other violations. Carl Civella is serving a 30-year prison sentence.

Anthony Civella was sentenced after pleading guilty to a charge of violating the Racketeer Influenced and Corrupt Organizations Act and with running a bookmaking operation with his father and other alleged members of the Kansas City organized crime family.

Authorities said that the organization was hurt in the early 1980s by the death of its undisputed leader, Nick Civella. Anthony Civella's uncle, and the convictions and imprisonment of several top leaders.

When Anthony Civella was released from prison, they said, he became the recognized leader and began to reorganize and reassert the family's control over some criminal activities.

Anthony Civella
. . . indicted in drug scheme

The indictment also indicated the FBI wiretapped telephones during the two-year investigation. It mentions two conversations between Civella and Clawson and one between Civella and Artese in which Civella gave them instructions.

The indictment also says the defendants met May 17, 1989, at an unnamed Kansas City hotel and restaurant.

The indictment alleges two separate schemes.

One involved all five defendants, who allegedly set up Kendallwood Pharmaceutical Supply and Care Pharmacy.

The other allegedly involved Sansone and four defendants, excluding Civella, who established Penn Park Pharmacy Inc. and Penn Park Institutional Pharmacy. Sansone was Civella's son-in-law and died by suicide in December 1987.

Civella, of 1509 N.E. 50th Terrace, is charged with six counts of interstate transport of fraudulently obtained goods and one count each of wire fraud and conspiracy.

Costanzo, Rubin, and Clawson each face 10 counts of interstate transport of fraudulently obtained goods, four counts of mail fraud, four counts of wire fraud and one count of conspiracy.

Artese, of 4603 N.W. Baltimore Drive, is charged with one count of conspiracy.

Chairman STARK. Mr. Teach.

STATEMENT OF RANDY TEACH, SENIOR VICE PRESIDENT FOR HEALTH POLICY, NATIONAL ASSOCIATION OF CHAIN DRUG STORES

Mr. TEACH. Thank you Mr. Chairman and members of the committee.

The National Association of Chain Drug Stores, NACDS, represents chain drug stores, and many supermarkets and mass merchandising retailers that operate pharmacies within their stores. A chain drug store is defined by the U.S. Department of Labor, and most other sources, as a company which operates four or more pharmacies. These drug stores dispense 60 percent of all outpatient prescriptions in the United States through more than 24,000 drug stores. In communities across America, more than 65,000 pharmacists provide professional service in our members' pharmacies.

A very large segment of the people served by chain drug stores are Medicare beneficiaries. We therefore have a very keen interest in H.R. 2500—the Medicare Prescription Drug Benefit Act of 1991. I would like to request the committee keep the record open so we can add comments when we can review the legislation further.

In 1989, after repeal of the catastrophic benefit, the chairman promised that he would be back with a drug benefit. Well, here we are. We applaud the chairman's continued efforts to include access to retirees and disabled to prescription drugs.

All of us have learned a lot from the catastrophic experience and it is now time to build on that experience. My remarks this morning will touch briefly on three areas that are central to both H.R. 2500 and chain drug stores. They are professional pharmacy services, pharmacy reimbursement and the point-of-sale system.

Each of these is explored in greater depth in the written statement. Just as the drug store has changed over the years, so has the role of the pharmacist. Today the role evolves around professional service. Chain drug stores strongly support this professional role. The participating pharmacist and drug utilization review provisions of H.R. 2500 recognize the importance of the pharmacist's professional judgment and service. They will assure that Medicare beneficiaries not only receive a prescription drug but also the advice they need to maximize their therapeutic outcome.

Regarding the payment for prescription drugs, the proposed formulas are similar to the methods used by the Medicaid program to pay for prescription drugs. Congress, in enacting the OBRA 1990 Medicare amendments, recognized problems with these formulas and placed a 4-year moratorium on changes that would reduce payments to pharmacies.

The moratorium was designed to provide time for the consideration of alternative payment systems. Because of the moratorium, our pharmacies are very sensitive to the reimbursement formulas as included in H.R. 2500.

Chart I of our testimony compares retail price increases with wholesale price increases. It shows that retail price increases have almost exactly paralleled those of wholesale price increases. That

means that retail community pharmacies have not profited from the increased cost of prescriptions.

In fact unlike other health care services, prescription drugs and medicines are highly price competitive. Furthermore, unlike other Medicare providers, pharmacies cannot make up revenue losses by increasing the volume of prescriptions dispensed, since volume is controlled by physician prescribing. We respectfully ask the committee to take this into consideration when acting on H.R. 2500 and allow time for the moratorium to work.

Another area of interest is the required point-of-sale system. Chain drug stores have committed to and invested in highly sophisticated computer pharmacy systems. Our members have opened their facilities to Members of Congress and the administration so they can learn about these systems, their capabilities and shortcomings. NACDS wants to emphasize to the committee the importance of the point-of-sale system to our membership and to the success of the proposed benefit. We believe that a fully functional system could serve as an industry standard for both private payers and for Medicaid programs, many of which are now grappling with the implementation of their own system.

In 1989, one of the factors that greatly complicated the implementation of the Medicare catastrophic drug benefit was the design of the point-of-sale system. Based on that experience, we urge everyone involved with the process to consider three basic suggestions: number one, build on current technologies. Two, phase in the implementation, so you don't have to do everything at once. Three, fully test the system before bringing it on-line. Remember, when the system goes on-line, it will directly affect the operation of up to 64,000 pharmacies.

We recognize that legislation cannot be drafted to fully specify such a system, but we hope the implementation can be facilitated by the establishment of a technical advisory committee to assist HCFA with the design and implementation of the electronic point-of-sale system.

In summary, NACDS appreciates the opportunity to appear before this committee and provide testimony. Our members thank you for offering a forum in which to debate a problem that deserves careful consideration. NACDS is committed to advancing public policy through sound research and thorough analysis.

We look forward to working with you on this most important initiative.

[The prepared statement follows:]

Statement of the National Association of Chain Drug Stores

Mr. Chairman, Members of the Committee: The National Association of Chain Drug Stores (NACDS) represents chain drug stores, and many supermarkets and mass merchandising retailers that operate pharmacies within their stores. A chain drug store is defined by the U.S. Department of Labor, and most other sources, as a company which operates four or more pharmacies. These drug stores dispense 60% of all outpatient prescriptions in the United States through more than 24,000 drug stores. In communities across America, more than 65,000 pharmacists provide professional service in our members' pharmacies. A very large segment of the people served by chain drug stores are Medicare beneficiaries. We therefore, have a very keen interest in HR2500 - The Medicare Prescription Drug Benefit Act of 1991.

Medicare Prescription Drug Benefit Act of 1991

NACDS applauds the Chairman's continuing efforts to address the problem of many retirees and disabled who do not qualify for Medicaid, cannot purchase private insurance coverage, and therefore cannot afford the cost of necessary prescription drugs. HR2500 would provide access to prescription drugs for many individuals with large and often times financially overwhelming annual prescription drug costs. The legislative proposal is sensible in that it sets a reasonable deductible - $650 for 1993. Individuals with limited annual drug expenses will not flood the system with claims, while those with a substantial expense will be afforded some relief. HR2500 offers a forum in which to debate a difficult problem that deserves careful consideration by everyone concerned with health care policy and delivery.

Professional Pharmacist Services

An important benefit of the legislation will be to assure that Medicare beneficiaries, the largest users of prescription drugs in America, will have ready access to pharmacist services, including drug use review and counseling. Pharmacists are, as they have been for more than a century, the most accessible of all health professionals. Study after study has documented that Americans admire their pharmacists, and therefore seek out and trust their advice.

Professional service is at the core of the drug store pharmacy. The role of the community pharmacist has changed over the years. In early years, America's pharmacists were principally compounders of medicines. With the advent of the highly productive pharmaceutical manufacturing industry, the American drug store has become a convenient, efficient, effective, and competitive distributor of prescription drugs and medicines, while at the same time becoming an active participant in health care delivery, patient information and cost containment.

The Medicare Prescription Drug Benefit Act of 1991 recognizes the important role of the pharmacist in its Participating Pharmacist Program and its drug use review (DUR) requirements. Chain drug stores strongly support drug use review and patient counseling in the framework of the professional practice of pharmacy. Mandated prescriptive requirements advocated by some in the profession are unnecessary, ineffective and costly. It is the free, professional judgment of the pharmacist that must determine the scope and extent of patient counseling, not prescriptive, mandatory government regulation. HR2500 is consistent with chain drug stores' view of DUR and counseling.

The value of professional pharmacy service has been well documented by the Department of Health and Human Services Inspector General and others. A recent Purdue University study[1] showed that pharmacists' screening for prescription drugs saved $2.32 in direct medical costs for every prescription dispensed, and an average of $123 for each pharmacist intervention. In addition, Pharmacy Card System (PCS), which processes more than 100 million prescription claims per year, in reviewing its drug use review system (RECAP), found that the elimination of duplicate and inappropriate prescriptions can save up to 4% of program costs[2].

It is important to note that the value of direct contact with a pharmacist in this process should not be underestimated. Patients' confidence in their drug therapy is strongly tied to the pharmacist's involvement with the dispensing of the drug product. We are therefore very sensitive to the establishment of uniform requirements for all pharmacy providers including physicians, mail order, and managed care. NACDS asks the Chairman and this Committee for their support in assuring that the requirements included in a Medicare prescription drug benefit be applied uniformly to all pharmacy providers.

Point-of-Sale System

NACDS supports the provisions in HR2500 that would build pharmacy participation around an interactive, on-line, real-time computer-based information system. The state of the art in computer hardware and software continues to improve and we are confident that a reliable and effective point-of-sale (POS) system can be implemented for the proposed Medicare prescription drug program.

Virtually all of NACDS' members have committed to and invested in highly sophisticated computer pharmacy systems. Our members have opened their facilities to both members of the Administration and Congress so that they could learn about these systems, their capabilities and their shortcomings. In 1989, NACDS worked closely with officials from the Health Care Financing Administration (HCFA) on their plans to implement a POS system for the Medicare prescriptive drug benefit. Through that process many potential problems were resolved and we all learned from each other.

One major problem that we experienced was that HCFA took the straightforward legislative language that required development of an eligibility claims adjudication system and expanded it to include information designed to assist pharmacists with drug use review. This system would have centralized information now maintained and used by individual pharmacies to advise physicians and patients about possible problems with a prescription.

While HCFA's goal for the system -- better patient care -- was laudable, it greatly complicated the implementation of the system. We expect that this could occur again with implementation of the POS system required by HR2500. Efficient claims processing is essential for the success of the program. We therefore urge everyone involved with this process to consider these three basic suggestions:

1) Build on current technology. Make sure what is implemented is compatible with the extensive network of systems already in operation.

2) Phase the implementation. Everything does not have to be brought on-line at the same time. Focus on claims adjudication first. Add DUR information at a reasonable and effective pace.

3) Fully test the system before bringing it on-line. Our members have vast experience with both developing and modifying computer-based pharmacy systems. A malfunctioning computer system creates a nightmare for record keeping, billing, and patient care. Remember when the system goes on-line, it will directly effect the operation of up to 64,000 pharmacies.

NACDS has specific concerns regarding the implementation of a POS system:

1) Medicare's requirement that providers coordinate benefits with other third party plans is a problem. There are virtually thousands of prescription drug plans. Not every pharmacy participates in every plan, therefore, coordinating benefits would be virtually impossible at the drug store level, but could be accomplished centrally by the drug claims processor (carrier).

2) The POS system must meet established industry performance standards before it is implemented. We are particularly concerned about the system's

response time. Slow response times will increase operating costs for both the federal government and for pharmacy providers.

3) The effectiveness and cost of developing an on-line, real-time centralized DUR system should be fully evaluated before it is implemented. An incomplete or out-of-date system could provide misleading information to a pharmacist and be detrimental to patient care. For example, claims information from prescriptions dispensed by a nonparticipating pharmacy would not necessarily appear on the system in a timely manner.

NACDS wants to stress to the Committee the importance of the POS system to our membership. We believe that a fully and properly implemented system could serve as an industry standard for both private payors and the Medicaid programs, many of which are now grappling with the implementation of their own systems.

We recognize that legislation cannot be drafted to fully specify such a system, but we hope that we can work with the Committee to include language in HR2500 that will provide more guidance to HCFA in the development and implementation of a truly effective and efficient POS System. The implementation process might also be enhanced by the establishment of an advisory committee to assist HCFA with the design of the electronic point-of-sale system.

Reimbursement for Pharmacist Service

Pharmacists' time is valuable, and we are concerned that the reimbursement formula that is included in HR2500 for Participating Pharmacies does not fully value the cost of providing the level of service required by the legislation and expected by patients. NACDS has long advocated a market-based approach to reimbursement for prescription drugs. Unlike other aspects of health care delivery, prescription drug prices at the retail level are very competitively priced - the only truly competition-based part of the health care delivery system.

This is because of the number and nature of the competition. There are over 53,000 drug stores in America. Almost every community or neighborhood has more than one. New competition has entered the market, including food stores, mass merchandisers, mail order, and managed care pharmacy; all of which add to a highly price-competitive mix of providers.

CHART I illustrates that since 1980 retail price increases have paralleled wholesale prices. At the same time, the cost of operating a pharmacy has increased. For example, the average pharmacist salary has increased 17.4% in constant dollars between 1983 and 1989 (CHART II).

Approximately 42% of prescriptions are covered by third party payments, and Medicare coverage of prescription drugs will significantly add to this coverage. The pharmacy department is the heart of today's community drug store, and the pharmacist is critical to the provision and promotion of health care. A focus on product cost without a commensurate concern about patient care will in the long term diminish patient outcomes.

Furthermore, pharmacies cannot be accused of offsetting losses due to price reductions and discounts through increased volume, as has been Medicare's experience with other health care providers. Pharmacists do not control the volume of prescription drugs; physicians do. In fact, pharmacists have been in the forefront of cost containment in a number of important ways. NACDS has long supported the use of generic drug products and has pursued legislation in every state to permit pharmacist substitution of multi-source drugs. Pharmacists also advise patients about over-the-counter medications and this practice may avoid unnecessary physician visits and prescription drugs. Additionally, community pharmacists are sensitive to and monitor patient prescriptions in order to identify excessive and duplicative use.

All of these factors have contributed to a rather stable expenditure for prescription drugs when compared to overall health care expenditures (CHART III). Furthermore, the prescription drug pricing of brand name products which has captured both newspaper headlines and the attention of Congress in recent years is largely beyond the control of community pharmacies. On the other hand, multi-source and OTC products are very competitively priced and are gaining increased market share (CHART IV).

The OBRA-1990 Medicaid amendments recognized the dilemma faced by community pharmacy. That legislation includes two important components that NACDS would like this Committee to consider:

1) A four-year moratorium on further reductions to Medicaid payments for prescription drugs. This was because the state Medicaid programs were under a mandate by HCFA to reduce payment for drug product costs by 10%, while the payment for dispensing the product had remained relatively unchanged over the past decade. This resulted in a significant reduction of approximately 9% in constant dollars

2) Recognition that America's drug stores are not the cause of retail drug price increases.

Because of the moratorium that is provided in OBRA-1990, NACDS and our chain store pharmacies are very sensitive to the reimbursement formulas as included in HR2500. In many ways they are a step backwards for us because, if enacted, these formulas would probably preclude the development of any meaningful payment reform as provided for by the Medicaid moratorium. NACDS and our chain store pharmacies are currently in the process of evaluating alternative approaches to reimbursement. We respectfully ask the Committee to take this into consideration when acting on HR2500.

Our review of the analysis conducted by CBO on the OBRA-1990 amendments shows that drug product costs increased from 65% to 71% of Medicaid program expenditures between 1984 and 1989, whereas the pharmacist fees decreased from 31% to 25% of expenditures. Wholesaler mark-ups remained stable at 4% during that time period (CHART V). A similar situation could occur if the reimbursement provision of HR2500 were enacted.

Regarding HR2500, there are several aspects of the payment system for participating pharmacies that concern us. One of them is a $5.00 administrative allowance for the dispensing of the prescription and the provision of professional services to a Medicare patient. Five dollars is below the true cost of dispensing a prescription. According to a scientific study, commissioned by NACDS and completed by the Pharmaceutical Economics Research Center at Purdue University[3], it cost the average chain drug store $5.46 to dispense a prescription in 1989 (CHART VI). Third party prescriptions, such as those covered by Medicaid or Medicare, added $.93 to this average cost because of carrying costs and other factors. There is clearly a shortfall in this one very simple part of the payment methodology proposed in HR2500.

Another area of concern is the method of updates included in the proposed legislation. The administrative allowance would be updated using the GNP price deflator. As depicted in CHART VII, this is the most conservative of all inflation indexes and far below either the CPI or Medical CPI. This means that in relationship to chain store pharmacy operating costs, participating pharmacies would lose ground year after year because the administrative allowance would not keep pace with the real rate of inflation. It also means that Medicare beneficiaries purchasing prescriptions from a non-participating pharmacy will pay proportionately more for them each year.

A second factor that concerns us is the frequency by which average wholesale prices (AWP) and the 90th percentile of actual charges would be updated. Retail pharmacy is subject to regular price increases from manufacturers of prescription drugs. If the biannual updates proposed in HR2500 are enacted, retail pharmacies will be paid at prices that are as much as 12 to 18 months old. While we have not yet conducted a thorough analysis on the effect that this would have on the 90th percentile payment limit, the

Pharmaceutical Economics Research Center at Purdue University in 1989 estimated that such a biannual update would result in a 10-12% reduction in the AWP payment limit.[4]

We raise these issues because chain drug stores have been committed to participation in publicly-funded prescription drug programs, despite the fact that Medicaid and other public programs result in losses totalling in the millions of dollars.[5] These losses must be subsidized by other segments of the drug store. This is no longer a reasonable or acceptable process. Adding Medicare to this list of programs would produce significant financial problems for many pharmacies. Therefore, it is important that the scope of the program benefits be balanced with the availability of adequate funding.

Finally, chain drug stores recognize that in this era of health care cost containment, Congress is not likely to pay the full retail cash price even when those prices are established by a highly competitive market. On the other hand, there are aspects of the proposed reimbursement formula that are troublesome and, we believe, could be modified without compromising the patient access and cost containment goals of HR2500. We would like to work with the Committee in a constructive, fact-based manner to achieve a mutually acceptable payment system for Participating Pharmacists.

Summary

NACDS appreciates the opportunity to appear before this Committee and testify today. In our testimony, we have attempted to verify and document areas that by careful analysis could further enhance the effectiveness of HR2500. NACDS is committed to advancing public policy through sound research and thorough analysis. We look forward to working with the Committee on this most important legislative proposal.

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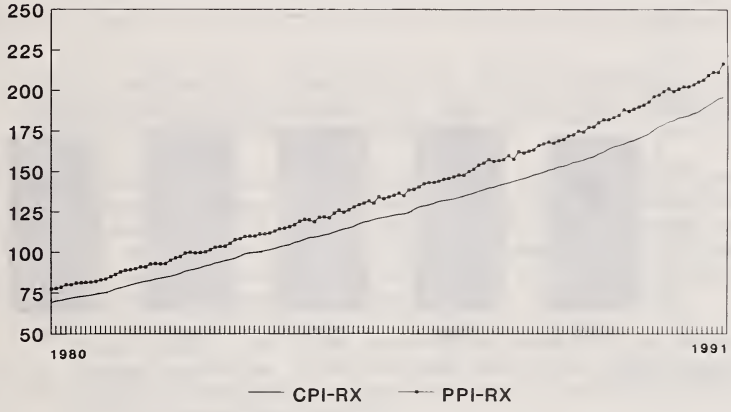
4. Pharmaceutical Economics Research Center, School of Pharmacy and Pharmacal Sciences, Purdue University.

5. NACDS Fact Sheet - *Medicaid Prescription Drug Program - Impact Analysis of Manufacturer Rebates, Drug Utilization Review, and Retail Pharmacy Reimbursement*, National Association of Chain Drug Stores, Alexandria, Virginia, August 21, 1990.

CHARTS

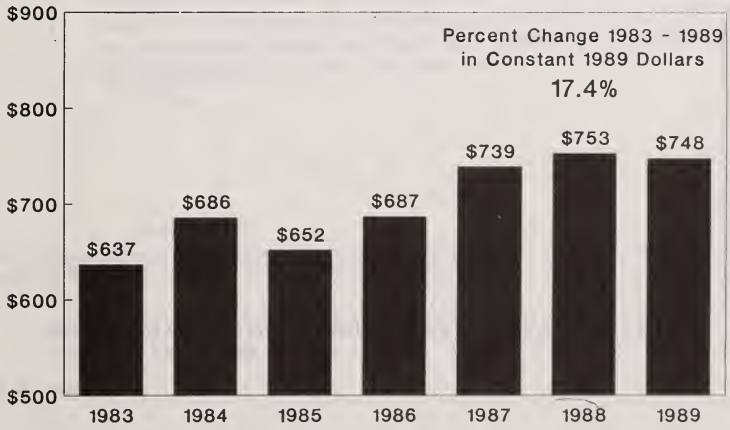
Chart I. Consumer and Producer Price Indices for Prescription Drugs 1980 - 1991



Source: U.S. Bureau of Labor Statistics

June 10, 1991

Chart II. Median Weekly Earnings of Full-Time Employed Pharmacists (in constant 1989 dollars)

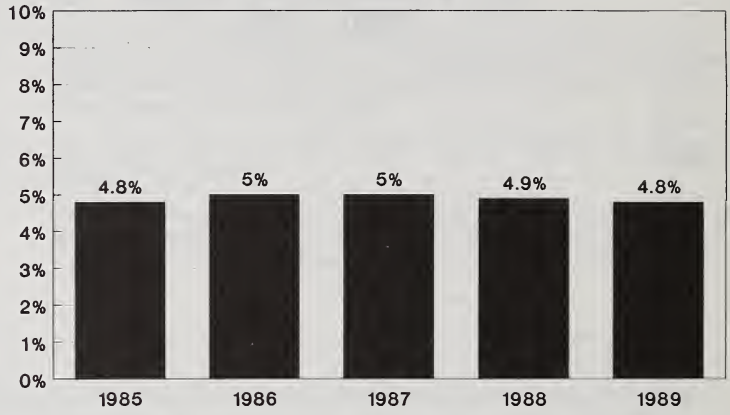


Source: U.S. Bureau of Labor Statistics

June 10, 1991

Chart III.

Prescription Expenditures as a percent of U.S. Healthcare Costs

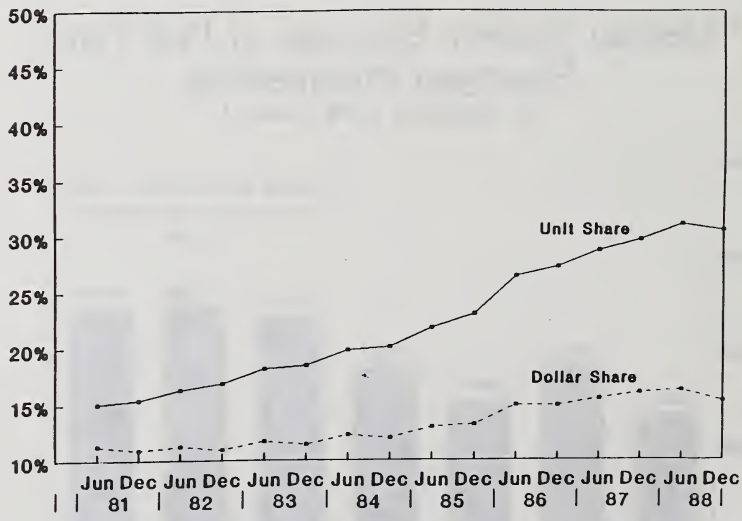


Source: HCFA

June 10, 1991

Chart IV.

NON-ORIGINATOR PRODUCTS' SHARE OF THE TOTAL DRUG MARKET IN DOLLARS AND UNITS



June 10 ,1991

FACT SHEET

Chart V.

MEDICAID PRESCRIPTION DRUG PROGRAM

RETAIL PHARMACY MARK-UPS FOR THE DISPENSING AND CONSULTATION FUNCTION ARE NOT THE CAUSE OF INCREASED MEDICAID PRESCRIPTION DRUG EXPENDITURES.

Federal Medicaid expenditures for prescription drugs will, according to Congressional Budget Office (CBO) preliminary estimates, amount to $3.0 billion[2] in 1991 and grow to $6.5 billion in 1995. This represents a growth rate that is 2.6 percent greater than the rate for overall Medicaid expenditures. Federal government program savings from $1.5 billion to $2.0 billion are achievable over the next five fiscal years. Two billion dollars over five years represents a savings of about 12%. According to CBO:

> **Drug Product Costs**[2] account for seventy-one percent (71%) of Medicaid program expenditures. Of this seventy-one percent (71%), fifty-five percent (55%) is for brand name and generic multi-source drugs and forty-five (45%) from single source brand name drugs.
>
> **Wholesaler mark-ups** related to the warehousing and distribution of drug products account for four percent (4%) of total Medicaid expenditures.
>
> **Retailer mark-ups**[4] related to the dispensing and patient consultation functions account for the remaining twenty-five percent (25%). These mark-ups have been severely restricted by the caps on pharmacy reimbursement for single and multi-source prescription drugs as administered by HFCA and the state programs. The result of these restrictions has been to reduce average retailer mark-ups since 1984 from thirty-one percent (31%) to twenty-five (25%),[5] and to reduce Medicaid payments to retail pharmacy to below the breakeven point (see section V. below). At the same time both pharmacy operating costs and drug product costs, as explained above, have risen sharply. For example, drug product costs as a percentage of Medicaid expenditures have increased from sixty-five percent (65%) to seventy-one percent (71%) since 1984.

Chart VI.

Comparison of Expense Categories for
Third Party and Private Pay Costs of Dispensing

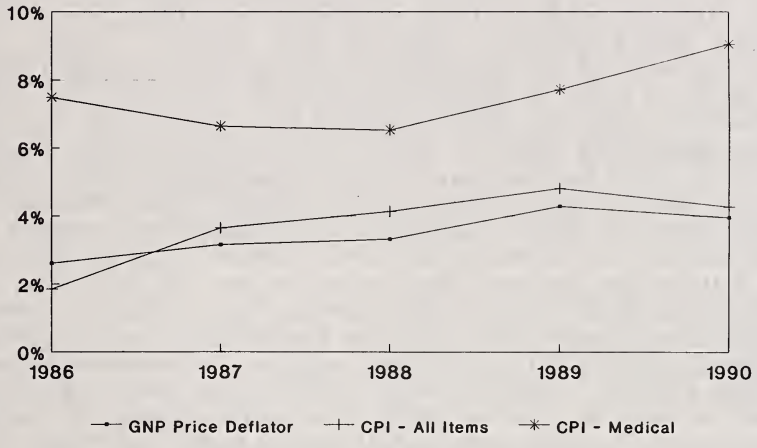
Category	COD Total	COD Third Party	COD Private Pay	COD Difference	t-statistic*	Significance*
Store Personnel	$3.69	$3.95	$3.59	$ .36	19.89	< .0001**
Rent	.26	.26	.26	.00	----	----
Direct Rx and Store Computer Expense	.32	.38	.30	.08	15.05	< .0001**
3rd Party Receivable Carrying Cost	.07	.23	.00	.23	45.21	< .0001**
3rd Party Bad Debt	.07	.24	.00	.24	19.89	< .0001**
Fixed Expenses	.15	.15	.15	.00	----	----
Variable Expenses	.29	.29	.29	.00	----	----
Central Administration	.60	.89	.56	.33	13.97	< .0001**
COST OF DISPENSING	$5.46	$6.39	$5.14	$1.25	34.34	< .0001**

* A one-tailed, paired t-test was performed to compare the third party and private pay expense for each expense category. The t-statistic and significance level (p value) of each test is reported and all tests had 694 degrees of freedom.

** These significance levels indicate that the difference between the third party costs and the private pay costs were statistically significant.

Chart VII.

Comparison of Percentage Change in Three Inflation Indicies



Source: U.S. Bureau of Labor Statistics

June 10, 1991

STATEMENT OF ROBERT F. ALLNUTT, EXECUTIVE VICE PRESIDENT, PHARMACEUTICAL MANUFACTURERS ASSOCIATION

Mr. ALLNUTT. Mr. Chairman and members of the subcommittee, thank you for the opportunity to testify on H.R. 2500, Chairman Stark's proposal to cover the cost of outpatient prescription drugs for Medicare patients. PMA represents more than 100 research-based pharmaceutical companies that discover, develop, and produce most of the prescription drugs used in the United States.

A recent study by the Battelle Medical Technology and Policy Research Center for Schering-Plough Corp. found that the use of pharmaceuticals saved 1.6 million lives and $141 billion over the past 50 years for just four diseases—tuberculosis, polio, coronary heart disease, and cerebrovascular disease. Future prospects are even brighter—if the incentives for pharmaceutical research and development are preserved and not weakened in the United States.

Battelle also projected that during the next 25 years the use of pharmaceuticals will save $68 billion in U.S. health care costs for Alzheimer's disease while reducing the number of severe cases by almost 400,000; $211 billion in costs for cardiovascular disease while avoiding 5 million deaths and 9 million cases; and $180 billion in costs for arthritis while reducing the number of disabling rheumatoid arthritis cases by half and the number of osteoarthritis cases by more than 20 percent.

Despite the progress that has been made in curing disease and the prospects for future advances, many diseases remain untreated. The research-based pharmaceutical industry is the best hope for finding new and better treatments.

According to a PMA survey last month, research-based pharmaceutical companies are involved in developing 329 medicines for diseases that primarily afflict older Americans. The health care costs of these diseases are staggering. The following table shows the number of drugs in development for seven major diseases that affect the elderly as well as the estimated cost of each disease and the source of the cost estimate:

Alzheimer's, annual U.S. cost, $88 billion, source of cost estimate, Alzheimer's Association, new drugs in development, 13; arthritis, annual U.S. cost, $35 billion, source of cost estimate, Arthritis Foundation, new drugs in development, 22; cancer, annual U.S. cost $104 billion, source of cost estimate, National Cancer Institute, new drugs in development, 126; cardiovascular, annual U.S. cost, $101 billion, source of cost estimate, American Heart Association, new drugs in development, 93; depression, annual U.S. cost, $27 billion, source of cost estimate, National Institute of Mental Health, new drugs in development, 16; diabetes, annual U.S. cost, $20 billion, source of cost estimate, American Diabetes Association, new drugs in development, 8; and osteoporosis, annual U.S. cost, $10 billion, source of cost estimate, National Institute on Aging, new drugs in development, 21.

In all, these seven diseases are estimated to cost $385 billion a year in the United States alone—an enormous figure that fortunately will be reduced as many of the 299 medicines in development to prevent, cure or treat the diseases are approved and marketed.

To discover and develop new medicines, research-based pharmaceutical companies have been doubling their investments in research and development every 5 years since 1970. In 1991, the industry is expected to invest $9.2 billion in R&D, up from $2 billion in 1980 and $4.1 billion in 1985.

This year the industry is investing 16.9 percent of its sales in research and development, up from about 11 percent a decade ago and far more than any other established industry. According to the National Science Foundation, all industries engaged in research and development on average invest less than 4 percent of sales in R&D—not even a quarter of the level invested by our industry.

While health care spending—just over 6 percent of gross national product in 1965—reached 12.2 percent of GNP in 1990, according to the Health Care Financing Administration, spending on prescription drugs remained well under 1 percent of GNP—just as it has for the past 25 years.

With this background on the key role of the pharmaceutical industry in promoting the health and productivity of U.S. citizens, particularly older Americans, I now turn to H.R. 2500. The outpatient drug provisions of this legislation are based on the provisions of the Medicare Catastrophic Coverage Act of 1988, which Congress repealed in November 1989.

H.R. 2500 would expand Medicare part B benefits to provide coverage for outpatient prescription drugs. Like the catastrophic law, H.R. 2500 would extend Medicare coverage to prescription drugs approved for safety and effectiveness by the Food and Drug Administration, certain prescription drugs first marketed prior to 1962, prescription biological products, and insulin. Unlike the catastrophic law, H.R. 2500 would not extend Medicare coverage to home IV drugs.

Some of the payment provisions of H.R. 2500 are similar to those in the catastrophic law—but there are very significant differences. As the catastrophic law provided, beneficiaries would be required to meet a deductible and to pay coinsurance under H.R. 2500. The Secretary of Health and Human Services would not, however, have the discretion to set the deductible as a means of controlling program costs under the proposed legislation—a major feature of the catastrophic law. Instead, the deductible would be $650 in 1993 and rise by $50 each year thereafter. Thus, H.R. 2500 could eliminate this administrative control over the number of potential beneficiaries and resulting program costs. In addition, H.R. 2500 would not establish a trust fund wholly financed through program premiums to pay for the drug benefit, as was provided in the catastrophic law, but would rely on the regular financing provisions for Medicare part B benefits.

Along with a number of other major health care organizations, PMA opposed the House-passed version of the catastrophic legislation because we believed it would have been inadequately funded from the start. Inevitably, underfunding would have led to draconian cost containment measures—such as denying Medicare patients the best of modern pharmaceuticals by limiting them to older, cheaper medicines.

In my testimony before this subcommittee on June 2, 1987, I stated:

The danger we see in hasty adoption of a new entitlement program—without carefully defining the problem so an appropriate solution can be devised—is that the costs of the program, and of its administration, will quickly exceed the initial estimates. As this subcommittee knows, underestimation of costs has frequently occurred in Federal and State health care programs. Such underestimation of the costs of a new drug benefit will lead inevitably to proposals for cost containment measures that would restrict freedom of choice, diminish quality of care and discourage the investment needed for future drug breakthroughs, thus denying those in need the benefits intended for them.

After House passage of the catastrophic bill, PMA worked with the Senate to help fashion its version of a Medicare outpatient drug benefit that had several built-in safeguards. These included, one, prohibition of a formulary, a limited list of drugs; two, secretarial authority to adjust the deductible in light of program experience, and three, provision of more adequate financial reserves. We supported the drug provisions of the Senate-passed bill in the House-Senate conference committee, which adopted the essential features of the Senate version. And we urged President Reagan to sign the final legislation, which he did on July 1, 1988.

Thereafter, revised estimates by the Congressional Budget Office and others indicated that, notwithstanding the Senate safeguards, the outpatient prescription drug benefit would be seriously underfunded. In June 1988, the CBO had projected ample premium revenues to support the anticipated expenses for the outpatient drug benefit. The CBO projected costs of $800 million in 1991 based on benefits for 16.8 percent of Medicare beneficiaries with a $600 deductible and 50 percent coinsurance, as provided by the law.

However, the results of the 1987 National Medical Expenditures Survey, NMES—released in May 1989—indicated that spending by Medicare beneficiaries was much higher than CBO had projected based on data from the early 1980s. Thus, in July 1989, CBO found that the cost of benefits in 1991 would be double what it had previously estimated. CBO also found that 26 to 27 percent of Medicare enrollees would receive drug benefits—instead of 16.8 percent as it had originally calculated. And CBO estimated that the outpatient drug program would incur a $2.7 billion deficit over 4 years.

A subsequent study by Project Hope's Center for Health Affairs, reported in the fall 1990 issue of Health Affairs, showed that even the NMES survey underestimated the cost of a Medicare outpatient prescription drug benefit. According to the study, "only a small number of respondents can report prescription drug expenditures with any degree of accuracy" in a household survey like NMES. The authors estimated that NMES understated spending for outpatient prescription drugs for Medicare beneficiaries by as much as 34 percent. The NMES indicated that aggregate outpatient prescription drug expenditures for the Medicare population would be $6.9 billion in 1987; Project Hope's figure was $10.6 billion.

The revised estimates clearly show that, had the catastrophic law not been repealed, Congress would have had to find more money for the drug program or severely cut it back.

As the subcommittee will knows, Congress repealed the catastrophic program in late 1989 in response to complaints from Medicare beneficiaries that they had to pay the entire costs of the new benefits. Since that time, PMA's board of directors has not had oc-

casion to consider any proposal to provide an outpatient prescription drug benefit under Medicare. Before taking a position, the PMA board would want to determine—particularly in light of the repeated cost underestimations of the catastrophic program—whether the proposal was fiscally sound. Otherwise, artificial and dangerous restrictions on patients' access to all approved medicines would become necessary or harsh and unfair restrictions on reimbursement would be imposed.

Let me depart from my testimony for a moment, Mr. Chairman. Yesterday we got from Project Hope a preliminary study that they have done at our request on the likely costs as they see them for H.R. 2500. I will be happy to furnish the study to the committee. I could summarize if for you by saying that they estimate, and the variable here is the amount of induced utilization, they estimate a cost of $8.3 to $9.9 billion in 1991 benefiting 44 percent of part B enrollees and $13.4 to $15.8 billion in 1996, with 45 to 48 percent benefiting.

I think we should pay particular attention to Project Hope's estimates because they were much more accurate than CBO's 2 years ago.

Finally, my statement suggests that in considering this program and the issues raised for the need of the elderly for drugs, that the subcommittee pay attention to two other sources of information, one is the recent action by NAIC on medigap insurance and the other is the State programs including New York, Pennsylvania, and Maryland for drugs for the low-income elderly.

There is a lot of experience there and a lot of promise in the medigap protection that you should take heed of before you move forward.

[The prepared statement follows:]

ROBERT F. ALLNUTT
EXECUTIVE VICE PRESIDENT
PHARMACEUTICAL MANUFACTURERS ASSOCIATION

BEFORE THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

JUNE 11, 1991

Mr. Chairman and Members of the Subcommittee:

Thank you for the opportunity to testify on H.R. 2500, Chairman Stark's proposal to cover the cost of outpatient prescription drugs for Medicare patients. PMA represents more than 100 research-based pharmaceutical companies that discover, develop and produce most of the prescription drugs used in the United States.

Prescription medicines are a critically important component of the nation's health-care system. Our industry strongly believes that all older Americans should be able to receive the medicines they need, and we welcome the efforts of this Subcommittee to take another look at the problems some elderly people face in obtaining necessary therapy.

The modern medicines our companies discover and develop enable people to live longer, healthier and more productive lives. Drugs extend lives, cure illness and improve the quality of life for all Americans, especially the elderly. Indeed, senior citizens are among those who most use and benefit from the medicines our companies discover and develop, as the Chairman indicated in introducing H.R. 2500.

Prescription drugs not only save lives -- they save money. Prescription drugs are the most cost-effective form of modern therapy. They save Medicare, Medicaid and American society in general billions of dollars a year by reducing the need for alternative, more expensive forms of therapy, such as hospitalization and surgery. The use of drugs also reduces the cost of physicians' services and the amount of time lost due to illness.

A recent study by the Battelle Medical Technology and Policy Research Center for Schering-Plough Corporation found that the use of pharmaceuticals saved 1.6 million lives and $141 billion over the past 50 years for just four diseases -- tuberculosis, polio, coronary heart disease and cerebrovascular disease. Future prospects are even brighter -- if the incentives for pharmaceutical research and development are preserved and not weakened in the United States.

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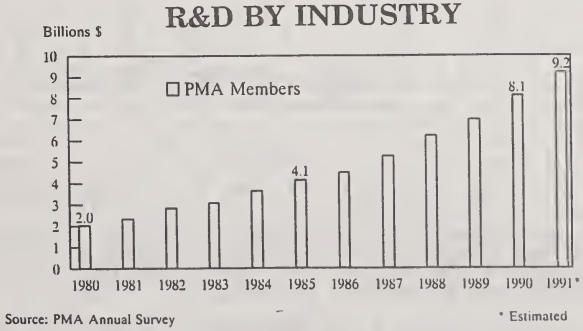
UNCURED DISEASES: COSTS AND PROMISING MEDICINES

Disease	Annual U.S. Cost in Billions	Source of Cost Estimate	New Drugs in Development
Alzheimer's	$ 88	Alzheimer's Association	13
Arthritis	$ 35	Arthritis Foundation	22
Cancer	$104	National Cancer Institute	126
Cardiovascular	$101	American Heart Association	93
Depression	$ 27	Natl. Inst. of Mental Health	16
Diabetes	$ 20	American Diabetes Association	8
Osteoporosis	$ 10	National Institute on Aging	21

In all, these seven diseases are estimated to cost $385 billion a year in the U.S. alone -- an enormous figure that fortunately will be reduced as many of the 299 medicines in development to prevent, cure or treat the diseases are approved and marketed.

To discover and develop new medicines, research-based pharmaceutical companies have been doubling their investments in research and development every five years since 1970. In 1991, the industry is expected to invest $9.2 billion in R&D, up from $2 billion in 1980 and $4.1 billion in 1985. (Figure 1.)



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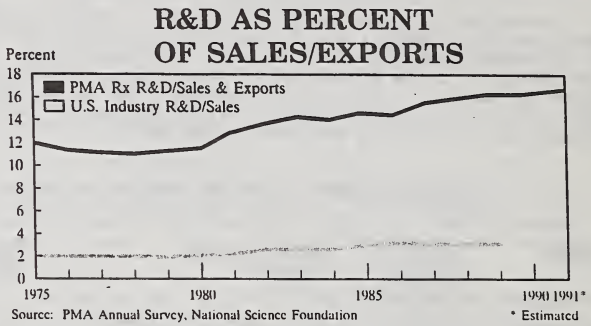

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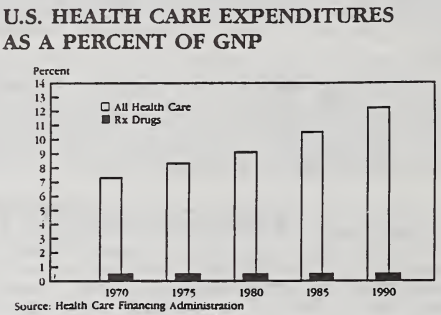
While health-care spending -- just over 6 percent of Gross National Product in 1965 -- reached 12.2 percent of GNP in 1990, according to the Health Care Financing Administration, spending on prescription drugs remained well under 1 percent of GNP -- just as it has for the past 25 years. (Figure 3.)



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Along with a number of other major health-care organizations, PMA opposed the House-passed version of the Catastrophic legislation because we believed it would have been inadequately funded from the start. Inevitably, underfunding would have led to draconian cost-containment measures -- such as denying Medicare patients the best of modern pharmaceuticals by limiting them to older, cheaper medicines.

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The revised estimates clearly show that, had the Catastrophic law not been repealed, Congress would have had to find more money for the drug program or severely cut it back.

As the Subcommittee well knows, Congress repealed the Catastrophic program in late 1989 in response to complaints from Medicare beneficiaries that they had to pay the entire costs of the new benefits. Since that time, PMA's Board of Directors has not had occasion to consider any proposal to provide an outpatient prescription drug benefit under Medicare. Before taking a position, the PMA Board would want to determine -- particularly in light of the repeated cost underestimations of the Catastrophic program -- whether the proposal was fiscally sound. Otherwise, artificial and dangerous restrictions on patients' access to all approved medicines would become necessary or harsh and unfair restrictions on reimbursement would be imposed.

PMA and many other major health-care organizations firmly believe that at a minimum any proposal for an outpatient Medicare drug benefit, in addition to being financially sound, must (1) prohibit therapeutic substitution, switching a patient from the drug prescribed to an entirely different drug; (2) permit a patient's physician to choose the most appropriate drug therapy; and (3) maintain the U.S. free-market in pharmaceuticals.

As I have stated, PMA fully shares the Subcommittee's goal of assuring older persons access to the prescription drugs they need. As you consider H.R. 2500, we urge you to review other efforts by Congress and the states to achieve this goal.

After the repeal of the Catastrophic law, Congress directed states to standardize options for private Medicare supplemental insurance policies. About 70 percent of the elderly had private Medigap coverage before the Catastrophic law was enacted, but Medigap did not provide for outpatient drugs and did not have standardized benefit options. This spring, the National Association of Insurance Commissioners (NAIC) agreed to 10 benefit plans for Medigap policies. Three of the plans include outpatient drug benefits. States must adopt the plans within a year after the NAIC has finalized them. Medigap policies with drug coverage will be more expensive than a basic Medigap plan without such coverage, but the comprehensive plans should be affordable to older persons of moderate means.

In addition, the Subcommittee may find it helpful to study state efforts to provide outpatient prescription drugs to lower-income older persons. A number of states have been operating and funding such programs for several years -- 14 years, in the case of New Jersey. The eight states (New Jersey, New York, Pennsylvania, Illinois, Maine, Rhode Island, Connecticut and Maryland) that provide this assistance attempt to strike a balance between fiscal restraint and the medical needs of lower-income older persons. These state initiatives should be closely examined so that any Federal program reflects what the states have learned in designing, operating and funding programs to provide outpatient prescription drugs for older citizens.

Mr. Chairman, that concludes my statement. I would be pleased to respond to any questions you or other members of the Subcommittee may have.

Chairman STARK. I want to thank the witnesses.

I received a letter, Dr. Gans, from you about manufacturers selling their drugs in Mexico at prices lower than here. In my home State, as you indicate, you can buy legal drugs for a hell of a lot less if you buy them on the street corner from people who run them across the border.

I wonder whether we should just change our trade laws and allow you all to go down and set up operations south of the border and allow the pharmaceuticals to sell drugs at reasonable costs to North Americans.

They are the same drugs. You can illegally buy steroids. I am trying to knock that out. I have heard more cockamamie ideas as to why I can buy drugs for a whole lot less in other countries, the same drugs, equally as safe. It boggles my mind.

Regarding the pharmaceutical manufacturers, I have a couple of complaints, when I see members of the PMA funding what I have to call front groups that make the Watergate burglars look sophisticated. You find there is a phone answering service at an advertising agency funded by the drug manufacturer with a front medical association saying doctors will withhold pain-killing drugs if we have the triplicate prescription law.

On Project Hope. I would not keep my staff around long if they did not come up with research that supported my opinion. But don't tell me Project Hope is independent. They are a shill for the pharmaceuticals industry.

Mr. ALLNUTT. I don't consider Project Hope a front.

Chairman STARK. Or a shill?

Mr. ALLNUTT. They are not here to respond for themselves. I doubt seriously if they would take that as a fair accusation.

Chairman STARK. But they take your money. You lie with the devil, my friend, and you make your own nest.

I am suggesting that their independence is subject to question. If you want to carry them along as a subsidiary of the PMA, that is fine but it offends me that you would come with a straight face and indicate to this committee that they are independent when you guys are footing them.

Mr. ALLNUTT. Mr. Chairman, the way you get a study done is to pay someone to do it. We paid them to do the study after your bill was introduced. They are not a front or a shill.

Chairman STARK. They are just a hired hand.

Mr. ALLNUTT. They were hired to do the study.

Chairman STARK. To do the study for you?

Mr. ALLNUTT. For the PMA, yes.

Chairman STARK. I think that says it all.

Mr. Cardin.

Mr. CARDIN. First let me say that I agree with much of what has been said by the panel in that the pharmaceutical development here in the United States has clearly saved billions of dollars of misery and cost to our elderly. We must be very careful in any plan that we come up with that we don't adversely impact the development and distribution of drugs.

Having said that, if you look at the figures, we have a major problem. We have a major problem of access today of many seniors

are not getting drugs that they need because they cannot afford the out-of-pocket expenses.

With 60 percent of our elderly not having prescription drug benefits of any significance and with an average out-of-pocket expense of over $500 a year, we are at that point where we need to deal with access and cost factors.

On the other side with more Government involvement, we are strapped for revenues. We don't have the money to pay for it. You are looking at cost containment. I would just make a plea that it is extremely important that the pharmaceutical industry work with us with these two problems of access and cost.

It is a comparable problem with those we have in other areas with health providers. We want to protect the way we distribute drugs in this country. However, it is disheartening when we find that for whatever reasons prescription drugs are available in other countries for less than here in the United States.

Maybe that has to do with the patent laws or other reasons. We understand the complexities of that. I am using my time to ask that we develop ways of controlling costs and expanding access. There is no way Congress will expand access for reimbursement for prescription drugs without imposing cost controls beyond what has been mentioned by you today.

I look forward to working with you and making sure that we do preserve the development of these wonder drugs which have helped all of our constituents here in the United States.

Chairman STARK. I want to thank the panel for their help. We will look forward to working with them as we have in the past on this issue. We appreciate your testimony today.

Thank you very much.

The subcommittee is adjourned.

[Whereupon, at 12:33 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

AMERICAN
NARCOLEPSY
ASSOCIATION, INC.
A NOT-FOR-PROFIT CORPORATION Est. 1975

335 QUARRY RD., BELMONT, CALIFORNIA 94002
TELEPHONE: (415) 591-7979; FAX: (415) 591-4934

June 25, 1991

The Honorable Fortney (Pete) Stark
Chairman, Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington D.C., 20515

Dear Mr. Stark:

The American Narcolepsy Association, Inc., a California based not-for-profit corporation which represents an estimated 375,000 narcolepsy patients in the United States, hereby expresses its support of H.R. 2500, "The Medicare Prescription Drug Act of 1991." We request that this written statement be published in the printed record of your subcommittee's hearing on the proposed legislation on June 11, 1991.

Narcolepsy is a neurological disorder which affects all populations in the United States, male or female, rich or poor, young or elderly. It is a lifelong condition with no known cure or preventive treatment. Effective treatment for daytime sleepiness and cataplexy symptoms of narcolepsy is available through prescription drugs. The medication must be taken daily to enable narcoleptic patients to have a semblance of a normal person's quality of life. The drugs are quite expensive, especially when limited to a maximum of a 30 day supply.

Eligible Medicare beneficiaries with narcolepsy will certainly benefit from the prescription drug coverage, though the actual prevalence of the disorder in the elderly population is not known. We assume that the regulations to be developed upon enactment of the bill will be drafted so as to assure that the treatment of narcolepsy with schedule II stimulant drugs is considered to be an "appropriate prescribing and dispensing practice."

Thank you for considering the views of the American Narcolepsy Association.

Respectfully yours,

Mary Lee Keane, President
The American Narcolepsy Association, Inc.

Statement of Terry S. Latanich, Senior Vice-President for Government Affairs, Medco Containment Services, Inc.

My name is Terry S. Latanich, Senior Vice-President for Government Affairs of Medco Containment Services, Inc. (Medco). I am writing on behalf of Medco to comment on H.R. 2500, the Medicare Prescription Drug Act of 1991 ("the Act"). Medco is the leading provider of prescription drug benefit programs in the United States, and specializes in providing pharmacy services by mail delivery to group health benefit plans. Medco believes that pharmacy services provided by mail offer significant advantages to elderly patients and should be an integral part of outpatient prescription drug benefits offered to Medicare subscribers.

The prescription drug benefit that was included as part of the Medicare Catastrophic Coverage Act of 1988, P.L. 100-360, established requirements for all pharmacies that decided to become "participating pharmacies". Mail service pharmacies were eligible to participate in the Medicare outpatient prescription drug program on the same basis as all other pharmacies. Medco believes that mail service pharmacies should be allowed and encouraged to participate in any future outpatient prescription drug benefit that may be adopted for Medicare beneficiaries.

Pharmacy leaders agree that pharmacists should counsel patients about the proper use of their prescription medicines. The 1988 Medicare prescription drug benefit required such services to be provided by participating pharmacies. Medco and other mail service pharmacies provide counseling to patients that is appropriate to their needs.

Medco provides counseling both through printed patient information inserts and by telephone. The patient information inserts used by Medco are developed by the United States Pharmacopeia, a respected national standard setting organization for the pharmacy profession and the pharmaceutical industry. Patient information inserts are available for approximately 90% of the new prescriptions dispensed by our pharmacies and are routinely included with prescription orders. Few retail drug stores provide such comprehensive written patient information. Medco's telephone counseling services are available free of charge to patients every day, with access to licensed pharmacists who are responsible for answering patients' questions about their medications. We put a high priority on our customer services: we insist on efficient, courteous service each and every time a patient calls.

Individuals who use Medco's mail service pharmacies do so voluntarily: they choose to submit and receive their prescriptions by mail. It is a safe and convenient way for older patients to obtain their medications. Medco's patients are able to receive medication counseling in the privacy of their own homes and at times convenient to them. The Inspector General of the Department of Health & Human Services issued a report last November on "The Clinical Role of the Community Pharmacist" which found that in the typical community pharmacy "pharmacists counsel only a small percentage of their patients, that consultations when they do occur are too brief, and that pharmacists' decisions in regard to patient care are often inadequate and inappropriate". Further, the Inspector General found that "the element of privacy, whether in person or on the telephone, is crucial to effective patient counseling." This crucial element of privacy is often lacking in retail pharmacy settings.

Medco and other mail service pharmacies and their pharmacists are regulated by the states and the federal government. Like retail pharmacies, all mail service pharmacies and their pharmacists are licensed by the state in which the pharmacy is located. Mail service pharmacies are regularly inspected by those state boards of pharmacy in accordance with applicable state laws. Pharmacists who practice in Medco's pharmacies must meet the educational and professional standards that are required of all other pharmacists in the state.

In addition, mail service pharmacies are subject to all federal laws and regulations that apply to retail drug stores. These laws include those enforced by the Drug Enforcement Administration (DEA) governing the distribution of controlled substances, and those enforced by the Food and Drug Administration (FDA) governing the purchase, sale, and distribution of medications that require a prescription. Indeed, Medco exceeds state and federal minimum labelling requirements by routinely including detailed package inserts with prescriptions, as discussed above. Medco must also observe the regulations of the United States Postal Service regarding the shipment of drugs through the mail.

Brandeis University and the University of Maryland conducted a study of mail service pharmacies for the Health Care Financing Administration as part of the Medicare Catastrophic Coverage Act of 1988. The "Brandeis study" found the following:

--Mail service pharmacies provide a viable alternative system for the delivery of maintenance or chronic-prescribed medicines.

--The quality of both the drug products dispensed and the pharmacy services provided by mail service pharmacies studied appears to meet generally accepted pharmacy standards of practice.

--The offer-to-counsel requirement of the MCCA ("Medicare Catastrophic Coverage Act of 1988") appears to be met through written information mailed with the prescription and the availability of toll-free telephone consultation for questions.

--Mail service pharmacies appear to have greater operational efficiency and resulting lower cost in certain areas, compared to community pharmacies.

The Brandeis report states that "comparison of prescription costs across practice settings such as community pharmacy versus mail service pharmacy must be made with caution" and the authors acknowledge that such costs are affected by several variables including the type of prescription filled and the days supply. In fact, the researcher who conducted the price comparison component of the Brandeis study, Professor Stephen W. Schondelmeyer, publicly stated in testimony before the Massachusetts Division of Insurance, in January of this year, that the Brandeis study did not make a fair comparison between the average daily charge per prescription dispensed by mail service pharmacies and retail drug stores.

The Brandeis analysis of pharmacy costs was based on incomplete data for nine of 39 identified mail service pharmacies, and the data on retail stores were derived from a survey that reported the lowest average retail charge when several other published surveys of retail charges reported much higher prescription charges. If one of these other surveys had been used for comparison, the reported savings from mail service pharmacy could have increased from five percent up to 40 percent. Further, the retail price data used in the Brandeis study failed to distinguish between acute and maintenance prescriptions. Typically, mail service pharmacies fill prescriptions for maintenance medications, whereas a high proportion of retail stores sales are for short-term, acute care medications. Pricing structures for these two types of prescriptions are markedly dissimilar.

On behalf of Medco, I wish to thank the Subcommittee on Health for the opportunity to offer our comments about the role and appropriateness of mail service pharmacies in providing safe and effective prescription drug services to Medicare beneficiaries as proposed by H.R. 2500.

Webb Clinic of Chiropractic

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WM P. WEBB II, B.S. D.C., Director

Congressman Pete Stark
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
1101 Longworth House Office Bldg.
Washington, D.C. 20515

June 5, 1991

Dear Congressman:

I'd like to address you and your subcommittee on health concerning your up-coming 06/11/91 hearing on Medicare Prescriptions and Drug Benefits.

My position is that my governmnet should not spend any further funds on prescriptions for those covered under Medicare. Although the press release of 05/13/91 quoted various statistics relating to prescriptions there is another side to this picture.

Seniors are programed to alter and suppress symptoms with little or no regard to their underlying causes.

Health care educators generally agree that the best and most rational approach to treating illness is to locate and eliminate the causes of the ailment. Once the cause is corrected the symptoms usually disappear. Suppressing symptoms is not consistent with the usually recommended health care procedures, and can even be dangerous. As an example side affects of prescritions are called "iatrogenic reactions." A study at the Yale New-Haven Hospital showed that 100,00 people die and 1 1/2 million others are hospitalized from iatrogenic reactions every yearin this country. That means each week, 2,000 people die and 30,000 are hospitalized from medications they take for illnesses, not from the illness themselves.

So it stands to reason that if my government is permitted to pay for more prescription use the amount of deaths is going to increase.

I hope you and your committee know seniors are well known to over-do their prescriptions and they also "fake" their symptoms to have prescriptions issued to them.

The also have prescriptions filled at government cost and sell or give them to others.

Really, there are many risks in raising the prescription allotment for Medicare.

Sincerely,

Wm. P. Webb II, Bs.D.C.

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